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PROPOSED VETERANS' ADMINISTRATION BUDGET FOR FISCAL YEAR 1988

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE-HUNDREDTH CONGRESS

FIRST SESSION

FEBRUARY 3 AND FEBRUARY 4, 1987

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PROPOSED VETERANS' ADMINISTRATION BUDGET FOR FISCAL YEAR 1988

TUESDAY, FEBRUARY 3, 1987

House of Representatives,
Committee on Veterans' Affairs,
Washington, D.C.

The committee met, pursuant to call, at 9 a.m., in room 334, Cannon House Office Building, Hon. G.V. Montgomery (chairman of the committee) presiding.

Present: Representatives Montgomery, Solomon, Edwards, Hammerschmidt, Applegate, Mica, Stump, Evans, Christopher H. Smith, Kaptur, Penny, Bilirakis, Staggers, J. Roy Rowland, John G. Rowland, Florio, Robert C. Smith, Davis, Kanjorski, Robinson, Stenholm, Harris, Kennedy, Patterson, Johnson, and Jontz.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

The Chairman. The committee will be in order.

Today we begin 2 days of hearings on the VA's proposed budget for fiscal year 1988. We will also hear testimony on the Administration's proposal to rescind $75 million from the amount appropriated by Congress for health care in the current fiscal year.

Our first witness this morning will be Gen. Thomas Turnage, the Administrator of Veterans' Affairs. Following his testimony, we will be hearing from four of the major veterans service organizations who have put together an alternative budget proposal.

This is the first time I recall that the veterans organizations have ever done this, so I look forward to their presentation and hope all members can stay to hear from them. I think you will find it worthwhile.

Tomorrow, we will hear comments from two chiefs of staff of VA hospitals, a hospital director and a chief nurse. We want to hear from these individuals to get some idea of the impact of the proposed budget in the field.

Over the past 4 or 5 years, the task of deciding budget priorities and how those priorities are to be met has been increasingly a job for the Congress. I expect it will be no different this year.

As in years past, the big controversy is going to be over the level of funding for health care. Overall, the proposed budget is not too bad. For example, the funding level for medical care is about $414 million higher than for the current fiscal year. But much of the increase is intended to cover uncontrollable payroll increases and the Federal employees' retirement system costs. In a real sense, the proposed budget is still short almost $300 million from a current services level. Should Congress enact this budget, it would actually require a reduction of some 3,800 employees from current employment levels. This budget would treat 13,600 fewer hospital inpatients and 113,000 fewer outpatients will be treated this year.

According to the veterans organizations' alternative budget, uncontrollable payroll costs and the cost of the new Federal employee retirement system will require $650 million more than we provided for health care in fiscal year 1987. The Administration's budget requires the VA to absorb a significant portion of these costs.

The Administration budget proposes a rescission for the current fiscal year of $75 million. I don't think there is a chance that Congress will agree to the rescission. I thought you ought to know that right off.

Activation of facilities that have just been constructed will require another 1,950 employees. This budget suggests that VA can have these employees as long as it is willing to give up about 2,000 employees through increased productivity.

This budget proposes to cut DVB personnel by about 300 people during the next fiscal year. My reading of the situation in the field is that loan guaranty applications continue to run high with interest rates at 8.5 percent. Applications for education benefits will increase this year and next year. Most stations cannot meet the timeliness standards already imposed on them by Central Office. So I see no way the department can take a cut of 300 people without adversely affecting the processing of applications. There is a lot more which we will get into this morning, and I look forward to hearing from the Administrator and the other witnesses.

I now yield to my good close friend and the ranking minority member of the committee, Jerry Solomon of New York, for any remarks he may have before recognizing the Administrator and his staff.

OPENING STATEMENT OF HON. GERALD B.H. SOLOMON

Mr. SOLOMON. Mr. Chairman, thank you very much, and Mr. Chairman, let me before I get into my short prepared statement, let me welcome General Turnage here and all of his able people that he has with him.

You know, it is a special privilege for me to see the General here today because before he became the Director of the Veterans' Administration he was the Director of the Selective Service System, and whereas all the credit for the Solomon amendment is given to me, I just want everyone to know that General Turnage, along with Geoffrey Gleason, who is sitting behind us, and who now is a member of the minority staff, were the people who authored that series of amendments, that resulted in more than 98 percent of all the young men in America living up to their obligations as U.S. citizens in obeying the law and registering for the draft.

So General Turnage comes along from background of good patriotic Americans. We welcome him here.

Mr. Chairman, at the organization meeting we were missing one new member on our side of the aisle. He was Jack Davis from Illinois, who has succeeded our good friend George O'Brien. Jack is a veteran, a naval aviator, and we certainly welcome him aboard.

Mr. Chairman, let me say that today in this committee, under your able leadership, we are gathered in a bipartisan effort to provide an informed view to the Budget Committee on the needs of veterans and the costs involved in meeting those commitments in a fiscally responsible manner.

I am certain our committee will meet the commitment in a timely manner as it has always done under your leadership and under the former ranking member, John Paul Hammerschmidt.

One week ago in the House chamber, Congress assembled to hear President Reagan's eloquent tribute to our Constitution, which begins with the words "We, the people".

This preamble clearly states that the people have granted power to their Federal Government to provide for a common defense of this Nation, and for more than 200 years and throughout many wars, this essential duty has been carried out willingly by America's veterans, often at great sacrifice.

They took care of America when they were needed, and "we the people" must never forget our obligation to take care of the veterans in their time of need. It should be, and I know that it is the priority of this Congress, to preserve the special meaning of the word "veteran" and to fulfill our obligations to our veteran population.

The Veterans' Administration has proposed a budget for fiscal year 1988 which is in most ways adequate to meet the wide and diverse needs of this large population. However, in some ways, the budget proposal falls short of adequacy in providing the funds necessary to carry out existing law.

The proposed 1988 budget for the VA is $27.6 billion in authorizations and $27 billion in outlays, and this does not include a proposed 3.5 percent COLA increase in compensation to be effective next December first.

There are a number of changes or cutbacks that are being proposed. You have already mentioned them, Mr. Chairman, and I won't repeat them, but if these proposals as they are presented are rejected, it would appear that perhaps about $350 million needs to be added to the $27.6 billion requested by the Veterans' Administration.

That is a small percentage of the $27.6 billion. I know we will fashion a budget in response not only to the current demand, but also in response to our continued philosophy that our veterans are special people with special needs and we are going to take care of them. In doing so, I think we should keep in mind that over the last several years, going back to the original belt tightening done under Gramm-Latta, the VA budget has taken more than its fair share of cuts. Although the Congress should always be ready and willing to streamline the delivery of services to our veteran population, this committee on a bipartisan basis will never allow the diminishing of the present level of attention and care that our veterans enjoy today, and yes, they are special, and they are going to stay that way.

Mr. Chairman, I would at this time yield to John Paul Hammerschmidt, the former ranking member for a brief statement.

The **Chairman**. The gentleman from Arkansas is recognized.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT

Mr. HAMMERSCHMIDT. Thank you.

I want to join you and Jerry in welcoming General Turnage, and the distinguished members of the Veterans' Administration that are here as witnesses this morning.

Mr. Chairman, the first hearing by the Veterans' Affairs Committee in the 100th Congress is on a subject of first importance, the VA budget. I know that our chairman, who is also my good friend, will be as vigilant as ever in examining the fiscal year 1988 budget proposal of the Veterans' Administration.

To my left is another good friend, Jerry Solomon, in whom I have the greatest confidence as ranking member. Together, all the members of this committee will give the proposed budget a thorough going over. Our bipartisan goal is to ensure a budget which is fair and adequate for veterans. In terms of dollars, that is going to mean enough for a basically current-services VA budget.

The $27.6 billion in budget authority for fiscal year 1988 requested by the VA is slightly more than the fiscal year 1987 budget. This proposed budget comes closer to the mark than any budget recently sent to us from the VA, and it goes a long way toward meeting veterans' needs. With some adjustments to the proposal, I believe we can achieve a level of expenditures which is consistent with the necessity of holding down spending while meeting a recognized national commitment to those who have defended our freedoms.

As ranking member of the Subcommittee on Hospitals and Health Care, I am especially concerned about the planned reductions in employment levels for the Department of Medicine and Surgery and in numbers of veterans for whom inpatient and outpatient treatment would be funded. Health care is a labor intensive service, and the number of veterans who need health care from the VA is not declining. Indeed, demographic data tells us that the number of older veterans is going to keep growing until after the turn of the century.

The proposal to cut out category C funding for the last 5 months of fiscal year 1987 and for fiscal year 1988 flies in the face of the historic health care eligibility reforms enacted last year. We cannot in one breath create an eligibility for health care and in the next breath consciously eliminate any possibility that there will be funds for those veterans.

There are other areas of the medical budget that will receive close attention as well, including the adequacy of research and construction funding.

As for an increase in the users fee charged to veterans using VA home loan guarantees, the Congress is very clearly on record as opposing any increase, as Mr. Solomon has already pointed out. But, on the other hand, if possible, we should not permit the Home Loan Guarantee Program to lose money. The program's operations can and should be improved in ways which would not deny access to it for the veterans it was intended to help.

The Administration has proposed a 3.5 percent COLA for disability compensation and DIC. The support for a COLA is welcome news. I feel certain it will be recommended by the committee.

In closing, I want to associate myself with Mr. Montgomery's remarks, and with Mr. Solomon's remarks, especially those about General Turnage, the VA's able Administrator. Working together, for common goals, we can hammer out a good budget for America's veterans.

Thank you, Mr. Chairman.

The **Chairman**. Thank you, John Paul.

Before I introduce the Administrator, his wife and daughter are in the audience, I would like for them to stand up. Mrs. Turnage and daughter, Andrea, we are certainly glad to have you.

General Turnage, I would like to echo what Mr. Solomon and John Paul Hammerschmidt said about your outstanding direction of the Selective Service System. A lot of good did come out the Solomon amendment which is the best record we have ever had on young men signing up. It wasn't a draft, just registration with the Selective Service System. Certainly you and Mr. Solomon and others deserve a lot of credit.

Over 98 percent have registered with the Selective Service System. I know you will do a fine job as Administrator.

The Chair recognizes the Administrator of the Veterans' Administration.

STATEMENT OF GEN. THOMAS K. TURNAGE, ADMINISTRATOR, VETERANS ADMINISTRATIOM, ACCOMPANIED BY THOMAS HARVEY, DEPUTY ADMINISTRATOR; DR. JOHN A. GRONVALL, CHIEF MEDICAL DIRECTOR; R.J. VOGEL, CHIEF BENEFITS DIRECTOR; ARTHUR D. HAMERSCHLAG, ACTING CHIEF MEMORIAL AFFAIRS DIRECTOR; AND DONALD L. IVERS, GENERAL COUNSEL

General **Turnage**. Thank you, Mr. Chairman.

In my new capacity at the Veterans' Administration we are opting for 100 percent. So we appreciate your support of that.

Mr. Chairman, and distinguished members of the committee, I am grateful for the opportunity to appear before you today, to discuss the Veterans' Administration fiscal year 1988 budget request.

At the outset, with your indulgence, sir, I would like to introduce the members of the staff who join me here at this table. On my right and your left, the Honorable Tom Harvey, who as many of you know, brings some very distinguished credentials with him to this job. He is a Vietnam veteran. He formerly served as a White House Fellow and also served in the Senate Veterans' Affairs Committee, so these proceedings——

The **Chairman**. We are very familiar, Tom Harvey is a distinguished American. We are glad to have him with the Veterans' Administration.

Mr. **Harvey**. Thank you, Mr. Chairman.

General **Turnage**. To my right is Mr. John Vogel responsible for veterans benefits, familiar to this body. To his right is Mr. Art Hamerschlag who is responsible for memorial affairs, also familiar to this body. To my left, I know that you join me in congratulating Dr. John Gronvall recently appointed Chief Medical Director after serving as Acting Medical Director on two different occasions, who brings distinguished credentials with him to include the fact he was——

The CHAIRMAN. Dr. Gronvall had his training down in Mississippi as an assistant dean at the medical school down there. I got some letters when you got this job congratulating you.

Mr. HAMERSCHLAG. He had his secondary training before this committee.

General TURNAGE. To the left is Mr. Don Ivers, who is General Counsel of the Veterans' Administration. I would also like to suggest that to my rear and enormously in the forefront is Col. Jim DeWire who is chief of staff of the Veterans' Administration and we are pleased to have him along with other members of our staff.

As we all know, this is my first budget presentation to your committee, and I have looked forward to the opportunity of addressing the budget. I would want to particularly thank and commend you who have chosen to serve our veterans by service on this very respected committee.

The CHAIRMAN. General, your full statement will be put in the record and I know you have a shorter statement——

General TURNAGE. Yes.

The CHAIRMAN [continuing]. So members have a chance to ask questions. It would be most helpful.

General TURNAGE. Thank you.

I want to convey in the strongest and most sincere form, we in the VA want to work with you congenially and professionally in serving all eligible veterans pursuant to the laws that you have enacted.

Budgets are more than facts, figures and dollars, the VA budget particularly tells an impressive story of service to special groups of citizens, veterans in need, many have served our Nation, deserving fellow citizens, for whom the Congress has assured specific care and benefits. It is my great privilege to lead an extraordinary group of Federal employees who are committed to carrying out the mandate of the Congress and the President to administer the many programs of care and benefits for these deserving fellow citizens.

Most veterans consider themselves citizens first. Most veterans are taxpayers who are generally concerned about fiscal year deficits and the future of their families, as well as their day-to-day responsibilities and needs. They sympathize with the enormous tasks we face together in finding and allotting resources to the person who needs and deserves them.

The current budget deficit means that each of us must do our share and we are willing to do ours. Even so, in my judgment, the Veterans' Administration has fared exceptionally well and the requested budget authority in 1988 exceeds any VA proposal to date.

The VA is requesting $27.6 billion to fund health care, compensation, and other programs for our Nation's 27.7 million veterans and their families.

Permit me to briefly summarize the VA's fiscal year 1988 budget request, highlighting some of the agency's major accounts.

BENEFITS

The largest portion of this budget request is for a benefit program which is at $15.4 billion that constitutes 57 percent of the total budget. About two-thirds of these funds, or $10.4 billion, will provide compensation payments to 2.2 million veterans and 323,000 survivors.

Another $3.8 billion will provide pension payments to 1.2 million recipients. We are proposing to index compensation benefits to the consumer price index, which is estimated to be a 3.5 percent cost of living increase for compensation recipients effective in December of this year.

In addition, legislation is being proposed making the plot allowance eligibility consistent with the burial allowance. It is estimated that the proposal will reduce 1988 funding requirements by some $31.3 million.

We are requesting $625.7 million to operate the readjustment benefits program in 1988. The program will provide training to 24,500 veterans in the vocational rehabilitation program and educational benefits to 183,000 veterans, Vietnam-era veterans, 43,300 dependents, 19,400 peacetime veterans, and 123,600 reservists. The budget for this program is $115 million less than the 1987 level because, according to our training trends, veterans are either exhausting their education benefits or reaching their 10-year delimiting date.

Legislation is proposed to establish the All-Volunteer Force educational assistance program, the New GI Bill, certainly at the initiative of this chairman, as a permanent recruitment and retention program for the Department of Defense. It is proposed that the Department of Defense budget for all benefits costs associated with this program.

In fact, the $20.4 million in basic benefits included in the readjustment benefit proposal request would be appropriated to the Department of Defense under this proposal.

These funds would be transferred to the Veterans' Administration along with the supplemental and reservist benefit payments. The VA would continue to administer all benefits associated with this program.

The loan guarantee program includes several legislative proposals. The primary purpose of these proposals is to make the program solvent, thereby eliminating the need for future appropriations and to increase private sector participation.

We are proposing that the 1-percent funding fee be increased to 2.5 percent. The increase in the funding fee is necessary to obviate the need for an appropriation.

The cost of this fee could be financed as part of a veteran loan. The increased fee, if financed, would increase the veteran's average monthly payment by less than $10 a month.

Based on the decrease in the interest rates from 17.5 percent in 1981 to 8.5 percent today, more affordable housing is available to more veterans today than in the past 5 years.

Other legislative initiatives include a proposal to allow the GI interest rates to be established by the free market forces of lender/borrower negotiations. In addition, legislation is proposed to im-

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prove the operation of the program after the veteran's loan has been guaranteed.

It should be noted that enactment of these proposals will not alter this program's primary mission of providing veterans with affordable housing without requiring a down payment.

In fact, we estimate that the VA will guarantee 340,000 loans in 1988, with a value of $26.7 billion.

The budget includes $34.4 million for the Department of Veteran Benefits to continue the modernization of the benefits delivery system, which will improve the delivery of services to veterans and to their dependents.

Projected savings as a result of this investment will enable costs to be recovered by 1994, just 3 years after implementation is completed. Also, the consolidation of the St. Paul and Philadelphia insurance operations will produce recurring annual savings of $1.7 million per year beginning in 1990, just 1 year after the consolidation is completed in fiscal year 1989.

Overall, employment for the Department of Veterans Benefits will decline slightly from 12,915 to 12,619.

MEDICAL CARE

Quality medical care for America's disabled and needy veterans is one of my highest priorities. Therefore, we are requesting a medical care budget of nearly $10 billion. The fund will provide for medical care and treatment of 1.4 million inpatients and 20.4 outpatient medical visits. Over 190,300 full time equivalents are requested to meet the medical needs of these veterans.

One of my major concerns, which I know you share, is providing for the needs of the aging veteran over the next few years. By 1990 there will be 7.2 million veterans who are 65 years of age or older. Our budget request both in extended care and medical research programs devotes increasing resources to meet the needs of older veterans.

In 1988 the VA will convert 282 existing hospital care beds into nursing home care beds. We will expand or open nursing homes in Minnesota, New York, and New Jersey.

Furthermore, our budget requests for grants for State extended care facilities will provide 371 additional nursing home beds and 450 new domicilary beds. Our 1988 budget for medical and prosthetic research is $198.8 million, an increase of $6 million.

A major portion of these funds will be used for medical rehabilitation research, designed to help the aging veteran, including research on heart disease, diabetes, cancer, and Alzheimer's Disease.

To help alleviate a growing nurse shortage, the Veterans' Administration will reactivate the Health Professional Scholarship Program. Funding is requested to support 1- and 2-year awards to nursing and physical therapy students. The 1988 budget for medical care requests resources to provide no cost care to all service-disabled veterans, to all prisoners of war, to all veterans exposed to toxic substances and radiation, and to all veterans of wars prior to World War II.

No cost care would also be provided to all veterans receiving VA pensions and those eligible for medicaid and to all veterans (with dependents) earning less than $25,000 per year.

The VA medical system is available to all veterans, but we should by law and by basic human instincts concentrate our efforts on providing care first for service connected veterans, and for those who are least able, to pay for their health needs.

This means that some veterans who are earning over $25,000 per year, and whose illnesses are completely unrelated to military service, may be required to use their own resources for obtaining health care in the private sector.

However, in locations where resources and space are available, our health care system will furnish care to these veterans. You have my word that no veteran no matter what his financial status is will be turned away from the VA facilities in an emergency or any dire circumstance.

We are requesting $47.7 million for the Department of Memorial Affairs, an increase of $3 million over the 1987 level. Total interments are estimated to increase 2.8 percent to 56,000. Resources for activation of the new national cemetery in Florida are provided.

Funding in our construction budget is also included for grave site development of the northern California national cemetery.

The VA request for 1988 construction funds of $525 million is 7.5 percent more than this year's construction budget. Major construction funds are proposed for 15 sites including the bed replacement project at Dayton and the patient and nursing home care building projected at North Chicago. The budget request also includes funds for clinical addition projects at Huntington, W.V., and Jackson, Miss.

Mr. Chairman, in closing, I want you to know I strongly support the efforts of the Administration and this committee to control Government expenditures. At the same time, I am committed to work toward the accomplishment of VA's mission to provide veterans the care, support and the recognition they have earned in service to this Nation.

Substantial savings are already being realized through implementation of a number of programs and management initiatives. Our budget request reflects concern for fiscal restraint while enhancing our ability to meet the needs of our veterans.

I appreciate the continued support and the guidance of this committee. This concludes my prepared statement and my staff and I are ready for a discussion of the detail of the request and will answer any of your questions or those members who have them.

The CHAIRMAN. Thank you for summarizing your statement. Without objection, the full statement will be put in the record.

[The prepared statement of General Turnage appears at p. 103.]

The CHAIRMAN. The Chair will implement the 5-minute rule for each member and for the new members that doesn't mean you have to take the 5-minutes. You will be recognized for 5-minutes. You will be recognized in the order that you came into the hearing after the meeting came to order.

The Chair will not take all of his time, but does want to ask the General one question.

On the GI bill, which you mentioned, we are slightly interested in that. It is a test program and it is now time to be made a permanent program.

This is from a personal viewpoint I am asking you this, General Turnage. First, when OMB said that the Defense Department would pay all of the cost of the GI bill, did you appeal that decision?

General TURNAGE. Mr. Chairman, in the deliberations preceding the decision, I had every opportunity and we used multiple opportunities, as a matter of fact, to make our views known to the Office of Management and Budget with regard to this particular issue.

The CHAIRMAN. What were your views then?

General TURNAGE. My view is the fact that the Administration has taken the position that this bill will be administered by the Veterans' Administration but funded by the Department of Defense. That is the position that I support.

The CHAIRMAN. Was that your personal opinion before OMB told you that you had to go along and support it? I got the impression that you supported the Veterans' Administration just like it has been done before, the Veterans' Administration would fund part of the program and the Defense Department would fund the other part.

General TURNAGE. Mr. Chairman, I am a member of the administration and I support the administration's position. However, with regard to the deliberations attendant to this prior to that time, I consider it to be executive privilege.

The CHAIRMAN. I think you are indirectly saying you supported our position, but don't want to get it on the record. Did you appeal this decision?

I got the impression that you did, that you did send a letter to the OMB and to the administration saying that you wanted the VA to participate in the readjustment program under the GI bill.

General TURNAGE. I made it known to the administration certainly that we were capable of and amenable to the idea of administering this program if, in fact, that was a decision that was made.

We also coordinated this with the Department of Defense and we coordinated this with your committee here. But the administration's position is the one that I——

The CHAIRMAN. Without objection, I will put in the record where you wrote them the letter, where you asked for them to repeal their decision.

General TURNAGE. If you have access to that, sir——

The CHAIRMAN. We will try to get the letter.

The Chair recognizes Mr. Solomon.

Mr. SOLOMON. Like I said, Mr. Chairman, General Turnage is a good soldier.

General, in this budget proposal, what happened to the proposal to consolidate regional offices? Where does that stand as presented in this budget?

General TURNAGE. We still have a proposal to do that, Mr. Solomon, and the details of that can be given now by Mr. Vogel.

Mr. VOGEL. Mr. Solomon, the only thing in the 1988 budget that speaks to consolidation is the consolidation of the insurance centers. We have no plans to consolidate regional office activities at this time.

Mr. SOLOMON. So there are no plans to consolidate regional centers other than in the insurance center that you are talking about?

Mr. VOGEL. That is correct.

Mr. SOLOMON. That is good and I am glad to hear that.

What is the current funding status of the Veterans Job Training Program as presented in this budget? Some of those funds are due to lapse and can you just bring us up-to-date. That program is very important to this committee and we would like to make sure it is going to continue and be properly funded.

Mr. VOGEL. Mr. Solomon, the available funding has been exhausted for the Veterans Job Training Act. There is still an opportunity for exploring whether or not funds remain available in fiscal year 1987. The Administrator has written to the Secretary of the Treasury for a decision or determination on the availability of these funds.

If funds remain available until September 30, 1987, we would estimate that with the deobligation of exhausting funds about $8.2 million would be made available through the end of this fiscal year.

Mr. SOLOMON. About how much?

Mr. VOGEL. $8.2 million is the figure we estimated would be available if there were a provision to carry over. Right now we are exploring that issue with the Department of Treasury.

Mr. SOLOMON. You had a $75 million rescission program in your budget proposal. Those funds, are they included in that in any way?

General TURNAGE. No, sir.

Mr. SOLOMON. They are not?

General TURNAGE. Entirely unrelated.

Mr. SOLOMON. We are not going to give you the $75 million rescission anyway. I wanted to make sure that those funds weren't in there.

General TURNAGE. Sir, whatever is right.

Mr. SOLOMON. Let's get on to what Sonny Montgomery was asking about, the All-Volunteer GI bill. What is your opinion of the GI bill? I guess, Sonny, we are going to be taking a trip pretty soon to review some of the military bases.

Can you give us your assessments of how that program is working?

General TURNAGE. Sir, I am a very active proponent of the New GI Bill. I have been ever since I was one of the fortunate recipients of its benefits after World War II and when it was finally decided by the administration to make this a permanent program, I was delighted to see that.

From my perspective, based on information that has been made known to me from the Department of Defense and others, it is still successful and as a result of the initiatives contained in that program they are getting a better quality of persons into the services now stimulated by VA benefit incentives than they have for some time. They are not only meeting recruiting goals, but are getting a better quality of personnel.

So it seems to me not only do benefits accrue to the individuals who take advantage of it, but ultimately benefits accrue to the Nation because of the fact that these people become educated and are more productive for the society as a whole. I think that has been the experience factor from those who have taken advantage of the program before, and I think it will be the same kind of result for the Nation in the future.

Mr. SOLOMON. I want to say that I share Sonny Montgomery's position that we really want to keep the GI bill in the funding and everything right in the Veterans' Administration. So you can take that back to the administration for both sides of the aisle on a bipartisan basis.

General TURNAGE. I understand that very clearly.

Mr. SOLOMON. At this point I have other questions, but maybe we could ask unanimous consent that all members be able to submit questions if they could in writing to the General and he could answer them.

The CHAIRMAN. Without objection.

Mr. SOLOMON. I yield back the balance of my time.

The CHAIRMAN. General, we will get off the GI bill, but I need to get it for the record now, did you appeal the decision of OMB that DOD pay all the cost of the New GI Bill? All I want is a "yes" or "no." We have been misinformed up here if you didn't do any appealing.

We ought to get it correct on the record. Either "yes" or "no."

General TURNAGE. Yes, I did.

The CHAIRMAN. That is all I wanted to know.

Dr. Rowland.

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Chairman.

Let me congratulate Dr. Gronvall on the new position that he has achieved.

I have a couple of questions that I would like to ask you, Dr. Gronvall. Professional liability is something that is really causing a lot of problems in the private sector. Can you tell me about the claims that may have been filed in the VA during 1986? And about how much this may have cost the VA in claims that were settled out of court, as well as those that went to trial?

Dr. GRONVALL. Mr. Rowland, I don't have any of that specific information at my fingertips. I would be pleased to supply detailed information. We, of course, do monitor our claims experience and the malpractice experience within the Veterans' Administration tends to mirror what is going on in the private sector with some difference.

Regularly I think we experience a much lower rate of malpractice claims, and settlement costs, than would be the case in a comparable private sector hospital. There are a number of differences in our system I think that contributes to that.

The malpractice problem of the country during the past year I would say has not represented an overwhelming crisis or major problem for Veterans' Administration. We have worked hard to implement changes within each of our hospitals to more expeditiously recognize problems in medical care, deal with those immediately, prevent problems from going to the point where they become malpractice claims.

But, again, we will supply the specific information about the number of claims, number of settlements. We can do that for the past several years so you can see the pattern.

[See p. 161.]

Dr. ROWLAND OF GEORGIA. That is really very interesting that the VA has not encountered as much because I think that maybe in looking at VA we might be able to find some answers for how to deal with this in the private sector.

I would certainly hope so and I would like to see what the trend was and what has been taking place and would like to certainly explore this area.

As you know, the VA has been a pace setter in many different areas. It has carried on vascular research, prosthetic research, and maybe we could find something in this area, and considering that VA is a pace setter, let me ask you about AIDS. In the VA, I think that the potential for AIDS, I suspect that you agree with me, as many physicians in this country are concerned that it is being exploitive, I think that many are really not aware of the potential. I think the potential is probably causing as much trouble as the plague did in Europe at one time. It is something that is sitting there waiting to explode.

Can you tell me what is taking place in the VA as far as research is concerned, how much money do you have budgeted for that, and what do you have budgeted for the treatment of AIDS? Could you respond on that a little bit?

Dr. GRONVALL. I would be glad to respond. I share your strong expression of concern about AIDS as a national and, in fact, an international epidemic that is still growing. It is not possible yet, unfortunately, to be able to predict even the ultimate extent of that medical problem in society, but it surely is growing.

Within the Veterans' Administration again, we tend to mirror the experience outside the Veterans' Administration. We have now treated something over 1,500 veterans who have had AIDS. Our general experience is that the distribution of our veteran patients again mirrors that in the broader society.

We have been particularly working to try to ensure that our hospitals that have a disproportionately large experience with AIDS are well prepared to deal with it. Our hospitals in New York, San Francisco, and Los Angeles, have tended to have the greatest amount of experience. We have not established a separate line item in the budget for care of AIDS patients.

As you know, of course, when an AIDS patient comes into the hospital for care, it is usually for one of the complications of the immune deficiencies. So we provide whatever care is appropriate for the particular complication that the patient has.

Last year we reviewed the financial impact of AIDS on our hospitals and allocated some $5 million of additional support to the hospitals that had had more than 10 AIDS cases. We haven't taken that additional step yet this year, but we are documenting the experience of our hospitals and will be dealing with that in some specific way.

We have extensive research going on. We are collaborating, of course, with the Public Health Service, in the Institutes of Health, we are working actively with a White House coordinating group that is intended to ensure that AIDS research and patient care throughout the entire Federal system is well coordinated.

So I think we are working very vigorously on the AIDS issue. Unfortunately, the end is not in sight, although there are some helpful signs with some of the new experimental drugs that are being tried including trials in some of our VA medical centers.

Dr. ROWLAND OF GEORGIA. I encourage the VA to step out front in this issue of AIDS. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Roy.

Just to follow up for the information of this committee, a service person, if he tests positive he is carrying the AIDS virus, then correct me if I am wrong on this, Dr. Gronvall, he is eligible for veterans treatment; is that correct?

Dr. GRONVALL. Correct as to those with disease rather than simply testing positive for HTLV-III antibodies.

The CHAIRMAN. We pick up these patients.

Dr. GRONVALL. Veterans who are being discharged from active duty because they have AIDS and are symptomatic are eligible for care in the VA.

[See p. 162.]

The CHAIRMAN. We were able to transfer $20 million from medical research in the military to the VA last year and it has helped out. If we are to get all the AIDS patients from the military, we are entitled to some funding, I would say, from the military to help work on this serious problem and maybe we can come up with a vaccine some day.

Dr. ROWLAND OF GEORGIA. I see my time is up. In respect of the $20 million, I had a question, perhaps I need to save that, since my time is up and I will ask Dr. Gronvall.

The CHAIRMAN. We congratulate you today. It is your birthday, and we wish you the best.

Dr. ROWLAND OF GEORGIA. Thank you very much.

[Applause]

The CHAIRMAN. As I pointed out to the members in our organization meeting, this is one of the few committees that applauds on Capitol Hill.

We are very glad to have Congressman Bob Stump from Arizona who has been on leave of absence for the last 6 years while on the Intelligence Committee. Bob, certainly glad to have you.

Mr. STUMP. Thank you, Mr. Chairman.

General Turnage, let me thank you for a very fine statement. I would like to follow up a question that Mr. Solomon asked, that is in regard to the $75 million rescission. I suppose the administration proposes this because of the $25,000 limitation. If that is so, and the reason for that to begin with was to allocate all of those funds to higher priority, why don't we transfer that money into some other area of higher priority rather than rescind it?

Maybe I am wrong in my assumptions, but I assume the administration proposes a $75 million rescission because of the limitation of $25,000 for higher income. Now, if that saving is so, and if it is there rather than rescinded, why don't we transfer it to other uses within the Veterans' Administration?

General TURNAGE. It would be a matter of conjecture on my part, Congressman. I can't tell you why. Because that initiative didn't come from the administration of the VA at the present time.

In so far as there was a change in the funding level for, in effect, category C for fiscal year 1988, as an early projection of that, they figured from June through October of this year, over $75 million would be the proportionate share that could be saved this year and the original objective, of course, was to help defray the level of the deficit and by simply shifting from there to some other part of the system, I suppose didn't meet that objective.

However, I might suggest to you, I don't know the full thinking behind it.

Mr. STUMP. Thank you. Let me ask you one other question.

In your statement you mentioned that the number of people drawing pensions has decreased by some 69,000. To what do you attribute this?

General TURNAGE. Well, first of all, I think it is simply the reduction in the number of eligible veterans based upon the numbers who are lost to us over a period of time.

Let me ask if Mr. Vogel can further expand on that.

Mr. VOGEL. I would be pleased to, Mr. Administrator.

It is caused by a number of factors, the most significant of which is improvement in the national picture with respect to providing annuities for the disabled and the elderly. It also reflects Social Security, private, and company-provided pension plans and mortality experience where the aged veterans previously receiving pensions have passed on.

In total, the number has been going down on balance in the last 8- or 10-year period. It is going down very rapidly.

Mr. STUMP. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Florio.

Mr. FLORIO. Thank you very much, Mr. Chairman.

General, welcome to the committee. I am going to ask a somewhat parochial question of some interest to some of us. My colleague from south Jersey and I asked it in the context of I think broad policy decisions that perhaps we can illustrate here. Over the last couple of years those of us in south Jersey have been expecting, and have been led to believe, that we would have our outpatient clinic constructed in that area. Therefore, we were extremely disappointed to see no authority and no funding provided in this year's budget as we were led to believe there would be.

Can you give us some understanding as to what the thought process is of the agency not having this money that we were led to believe would be included in the budget?

Dr. GRONVALL. Mr. Florio, I can comment on that and I think reassure you that our plans are proceeding for an outpatient clinic in Ocean County, N.J. The fact there is not a specific request in the budget for 1988 relates to the strategy we are using for planning and the time table of how that clinic will be created. We are completing a cost analysis that will show us the most advantageous way to bring that clinic into being. By that I mean whether the VA should build it or whether we ought to lease it from a private sector offeror.

Recent experience has generally been that lease arrangements have turned out to be the most cost beneficial to the VA. Going on that assumption, and looking at the time table, if a lease agreement is signed during 1988, which I expect will be the case——

Mr. FLORIO. Fiscal year 1988?

Dr. GRONVALL. Fiscal year 1988. We do not need a specially identified category of funding in the budget. We have a general category of funding from which that kind of lease payment would be made.

When the lease agreement is signed, in fact, if it is a lease agreement, with a private sector contractor, it will take some period of time, perhaps 10 to 12 months, for a clinic building to be either built or an existing building to be renovated to meet our needs. If it turns out that we decided to build the clinic ourselves, then we would request construction funds in a subsequent budget.

Mr. FLORIO. Let me only, because we have limited time, you are suggesting, notwithstanding no reference to the budget submission, you have the authority to enter into a long-term lease that would be sufficient to a private sector entrepreneur to construct an $18 to $20 million building and provide that contractor with the assurances, that is, lease payments would be sufficient to cover his mortgage payments over that period of time.

Dr. GRONVALL. Our current plan is that we will, I believe, make an award in April of 1988.

Mr. FLORIO. You say you will make the award during 1988. An award of what?

Dr. GRONVALL. We would have completed our planning and if it is going to be lease arrangements then we would sign a lease agreement.

Mr. FLORIO. I guess that is my question, a lease agreement that would justify a contractor to construct an $18 to $20 million facility has to be a fairly substantial lease to justify that entrepreneur putting that money into the facility. Forget the operating cost, which is not even calculated here, I would like to know if you have the authority to enter into such a long-term lease to amortize the costs of a construction over a facility, without any reference to that in the budget. Perhaps the counsel would be the best person to ask that.

Mr. IVERS. We have the authority, Congressman, to enter into long-term lease agreements. These lease agreements do not necessarily entail construction. It would depend on the existence of available space within the communities which are part of the survey that is being done now, as I understand it.

Once that is done, we would then determine how to approach the community to obtain the space that was anticipated, whether there is available existing space, or whether a low bidder would come in with a proposal.

Mr. FLORIO. Again, I apologize for interrupting you. We have limitations on time for benefit of the General, to give him 2 minutes worth of his try of this because I know he is really new. We had in south Jersey a commitment, authorization, appropriation, an allocation, of $60 million for the full construction of VA hospitals in 1980. Land was acquired, homes were demolished, people moved, contracts entered, and then the new administration came in in 1981, rescissions took place, even though we had spent $5 million.

Since that time, we have had held out to us the prospect that in lieu of the hospital, we would have this outpatient clinic. Every year that representation has been made.

We are now getting into fiscal year 1988, and nothing at all in the budget. I think there is a serious question even on the basis of explanation from the learned counsel as to whether this new approach of the construction of the facility, or the utilization and modernization of some other facility, is going to be able to be financed through a lease arrangement, almost a lease back arrangement.

I would just hope and I would ask the chairman that we would give some serious consideration in our submission, in our recommendations, and in the action that we take, to deal with this problem once and for all.

It is almost disingenuous to hold out the prospect to veterans in our area. We have been hearing this year after year after year. To think that something may very well happen when we are talking about preserving the status quo through the budget process.

We are talking about rescinding $75 million and the hope that we are going to spend money, I applaud it, I will work for it, but it is not going to happen.

We, ought to fish or cut bait. Tell people that is the case so we can move on to other types of options, to provide services. So I would just share that history with the General so that he knows where at least some of us are coming from in this initiative.

I thank the gentleman for his cooperation.

The CHAIRMAN. We are going to have a veterans construction hearing in the near future and the Chair will try to help the two gentlemen from New Jersey, on the outpatient clinic in south Jersey that you have been quite interested in over the years, so the Chair will do what he can on that.

Without objection, the gentleman from Massachusetts, Mr. Kennedy, wanted to ask one question along the same lines. The Chair recognizes the gentleman for 2 minutes.

Mr. KENNEDY. Thank you, Mr. Chairman.

General Turnage, I understand from your testimony, first of all, that you have increased your budget by $414 million. However, I also go through the budget and find that there are 5,801 jobs that are going to be eliminated by the VA between now and 1991. One of the initial ones, as I understand it, is the elimination of a New Bedford outpatient clinic in Massachusetts that will now require veterans to travel more than 75 miles to receive outpatient care.

I wonder whether or not, first of all, that is true and, secondly, what we can do about it?

General TURNAGE. Let me ask Dr. Gronvall to give you the specifics about New Bedford, Mr. Kennedy. Once he does that, then I want to take 1 minute to tell you about the information or dynamics affecting this situation which I think is very important to understand, if I may.

Dr. GRONVALL. Yes, sir. Without trying to get into too much detail, Mr. Kennedy, I can say that we have studied our New Bedford satellite outpatient clinic in detail over a number of years. We have tracked the fact that the work load at that clinic is declining.

The veteran population that it serves is declining. And it has come to the point where we believe that in the interest of the best use of the total amount of funds that we have, it would be desirable to terminate the operation of that clinic. The veterans currently served by it have access to other Veterans' Administration facilities, hospitals and clinics in the area, and we believe that it is a responsible proposal in this context.

Mr. KENNEDY. As I understand it, you do have certain guidelines this particular clinic would have adhered to if, in fact, this were to be a new facility such as Mr. Florio has, one that was going to be constructed, and so, therefore, I don't know whether or not there might be some changes in which, if you are going to shut down an outpatient clinic, they ought to adhere to the same guidelines that are required for the building of an outpatient clinic.

General TURNAGE. What we are doing——

Mr. KENNEDY. I don't mean to be exchanging your outpatient for our outpatient, but nevertheless, the veterans of Massachusetts are very concerned.

Dr. GRONVALL. I believe it would be helpful if I gave you specific figures. Going back to 1981, that clinic saw nearly 9,000 veteran visits. By 1986 it was down to 6,000 visits. That is a 30-percent decrease over that period of time. And as we project forward the demographics of the area, we project that downward trend shows that basis of believing that that clinic ought to be closed.

Mr. FLORIO. He has made my point. I am concerned about the proposals of new ones when you raise the very legitimate observation that there are old ones being closed.

Mr. KENNEDY. Yes.

General TURNAGE. Managerially and philosophically, I must suggest that we are involved with a moving train here and it is very difficult for any area of the country to consider the possibility of a diminution of services simply because of the emotional as well as some realistic impact that has. However, from the same point of managing of the system, you have to understand in the country there are many dynamics impacting on this, and we find that in some areas of the country where the services that before were needed legitimately, now are no longer needed at the same level.

I am not privy to the information about the hospital in New Jersey, sir, but I am privileged to know about the plans for the outpatient clinic. We have, for example, on an ongoing basis continued changes in the construction programs that are going on in the system simply because of population changes, because of the reduction in the numbers of veterans who would be in a particular catchment area, because of dollars and a number of other reasons. The fact is we are dedicated to take care of the veterans to the extent that it is practical and needed because this is our job and we will do that.

However, you can appreciate the pressures that exist in any one area when we think of changing either a plan based upon some of the dynamics I have suggested or based on the fact that changing from a hospital to an outpatient clinic or a similar type of arrangement, the impact that that has.

Mr. KENNEDY. General, the chairman has been kind enough and the other more senior members kind enough to allow me to speak so I won't pursue it much longer than to ask the chairman if perhaps we could develop some sort of national plan. We don't need a Veterans' Administration that says 6,000 outpatient visits occurred in 1986, and then says an outpatient clinic is not needed by those 6,000 individuals that obviously did utilize that facility last year. It seems if we could have some sort of national plan that would allow us to have some uniform guidelines, people out in the field are going to have a better understanding of what we are trying to accomplish.

The CHAIRMAN. We have the same problem at Walla Walla, Wash. They are changing the mission of that hospital, and that is a very fine suggestion. Dr. Gronvall, how long would it take your staff to put together a national plan?

Certainly this piecemeal operation is not working very well and you do need a national plan.

Dr. GRONVALL. We do have a set of criteria for outpatient clinics that describes the basis on which we review proposals to establishing outpatient clinics. So, to the extent that the committee would like to see a set of criteria, we would be pleased to supply that.

Those are general criteria but with fairly specific details in them and then beyond that, each individual proposal either to establish a new clinic or to change the function of an existing one, is an individual review of the detailed sort that takes into account demographic projections, availability of services, and other nearby facilities.

The CHAIRMAN. Doctor, would you send a national plan up to this committee to look at? As far as I know we don't have a total national plan. We would like to have one updated if you would do that.

Dr. GRONVALL. We would be pleased to do it and we can include the set of criteria that we have used and the projection of planning for satellite outpatient clinics. We would be pleased to do that.

[See p. 163.]

The CHAIRMAN. The Chair recognizes the gentleman from New Jersey, Mr. Smith.

Mr. CHRISTOPHER H. SMITH. Thank you, and notwithstanding Dr. Gronvall's apparent assurance that south Jersey, central Jersey clinic will be constructed, I do want to express my very profound disappointment that in this budget submission, monies, authorization for the clinic have not been included. On at least two occasions during Hospitals and Health Care Subcommittee hearings last year, I asked Dr. Ditler point blank if the money was to be included in the submission in fiscal year 1988, and his answer was "yes."

Last year, I think Mr. Florio touched on this very well, we have had a history of being dependent in central and south Jersey, first, for the hospital in Camden, which Mr. Florio had led and secondly, for the outpatient clinic.

When you talk about criteria, Dr. Gronvall, the number of patient visits to the south Jersey clinic would be something on the order 52,000 per year, clearly exceeding the criteria that had been established by the VA.

I have been pushing for a clinic for 5 years, and in 1984, we had a DOD sharing agreement work out for Fort Dix which at the very last minute the rug was pulled out and we lost that outpatient clinic.

So then we had the 1984 study which demonstrated that need, put the Ocean County clinic in the very top of the list and now we are being deferred time and time again.

Last year's members will recall I took the extraordinary move of offering an amendment to direct the VA to establish such a clinic. It passed unanimously. It passed on the floor. Unfortunately, it was dropped in the House-Senate conference committee. I have again taken the extraordinary step of introducing the legislation to direct the VA to establish this clinic because we don't know when this is going to happen. We have been frustrated. I have to say that very clearly, General. We have been frustrated.

Year in and year out we have gotten promises and year in and year out we hear maybe next year, maybe next year. I can assure you, Mr. Chairman, when the right opportunity avails itself I will again offer this as an amendment, if for no other reason, to send that signal to the VA that we want to have the clinic. The need is overwhelming.

I would urge you, Mr. Chairman, and urge you, General Turnage, to include money in the budget for this clinic; and we are going to do everything we can on this committee to ensure that it is established in the shortest possible time. I would just ask you, if you would, to comment on the time frame. I know you began to give April of 1988. Was that the time frame? You talk about a lease if this does go forward.

Dr. GRONVALL. Yes, our current schedule on the clinic is moving along, and the planning is that we would now project that in April of 1988 a lease agreement would be signed. In the budget there are funds identified in the category of leasing. The 1988 budget includes a fund request that would allow us to fund about four satellite outpatient clinic leases, although the individual clinics are not identified in the budget.

Mr. CHRISTOPHER H. SMITH. Of the four, are any of the other clinics of a higher priority?

Dr. GRONVALL. I don't know the answer to that. I have been asked to supply our national plan, and we will submit for the record the criteria for outpatient clinics.

[See p. 163.]

Mr. CHRISTOPHER H. SMITH. I have read that criteria very carefully, and I hope any new submission of a national plan will not cause another re-evaluation and another deferral because we really, frankly, have had it. That south Jersey hospital that Mr. Florio championed for many years, money was spent on it and it was rescinded. Now we are talking about a clinic where there are minimal expenditures, and clinics are proving their worth throughout the country—52,000 visits guaranteed. I think that far exceeds perhaps any other clinic that is pending before us.

Mr. FLORIO. Will the gentleman yield?

Mr. CHRISTOPHER H. SMITH. Yes.

Mr. FLORIO. I ask the counsel, or anyone for that matter, is there any experience whatsoever in the VA with regard to the approach that has been represented to us that you are considering here, not leasing only an existing facility? There is a specific situation that the lease mechanism itself can be used to induce a private sector contractor to build this facility and the lease would be able to be used in the sense almost as the financing mechanism. Someone walks in the bank and says: "I have a lease from the VA. Provide me the construction money to go and build this facility."

Has that device or that approach been used by the VA for the construction of any other facilities?

Mr. IVERS. Yes, it has, Congressman. We have one in progress in Crown Point and another in Evansville, both in Indiana. I am not familiar with all of the other outpatient clinic projects. We have been using that device for a period of 3 years under a delegation from the General Services Administration which has used the same device for over 30 years.

Mr. FLORIO. I thank the gentleman.

Mr. CHRISTOPHER H. SMITH. Dr. Gronvall, you indicated in your statement that Ocean County was the site that is under active review. Is that still the case or are there other sites?

Dr. GRONVALL. Ocean County is not under active review. We are actively planning the creation of a facility in Ocean County. It is not a matter of review. I have just been handed some information. We have a total of 12 satellite outpatient clinics that are at one level or another of planning. Two are specifically identified in the current budget: namely, Crown Point, Ind., and Ponce, Puerto Rico. The next five have been approved at the level of approval to proceed to implementation planning, and that next five does include Ocean County, New Jersey, and that's the basis of my statement that it's in the implementation planning phase, and our projection would be to sign a lease agreement in early 1988.

Mr. CHRISTOPHER H. SMITH. When can we expect the doors to open to this clinic?

Dr. GRONVALL. I think that would depend a little, of course, on whether there is a decision for the VA to build it or whether it's a lease. Our experience, I think, has been that in leased clinics once we sign the lease it often takes 10 to 12 months for a building either to be built by a contractor or if there is an available building for renovations to be conducted suitable so we could move in. So that would depend on the specific way the clinic is brought into being.

Mr. CHRISTOPHER H. SMITH. Thank you.

The CHAIRMAN. The time of the gentleman has expired.

For the record, Mr. Staggers of West Virginia had to leave.

Mr. Robinson of Arkansas is here.

The Chair would like to welcome the ranking member of the Veterans' Affairs, Mr. Don Edwards, for any comment he would like to make.

Mr. EDWARDS. Thank you very much. I am sorry I am late. I got stuck in a traffic jam. It is getting as bad as California around here.

Mr. Administrator, I join my colleagues in welcoming you here today. I was wondering if you could bring us up to date on the VA nurse situation. It is very serious in California, 26 percent turnover. You are apparently paying them $10,000 a year less than nurses can get in the private sector. In one hospital near San Francisco the turnover rate in the intensive care unit is 46 percent a year.

So my question, Mr. Administrator, is: What are your plans to straighten out the nurse situation?

General TURNAGE. Congressman Edwards, we are very conscious of the problem, and just recently we completed a national survey to determine not only the situation relating to nurses but also to other critical specialties within our system, to include pharmacists which we find is a national situation.

In the case of nurses specifically, across-the-board on a national basis we have sufficient nurses to meet our needs. In spots throughout the Nation, especially the urban areas, including one of the most notable which would be your area that you are talking about, Palo Alto, San Francisco, so forth, New York City, Miami, Los Angeles, we have there a competitive problem with the private sector where we are experiencing the national shortage of nurses. These people are paying prices that woo away some of our nursing staff. It becomes a competitive event then.

(Subsequently, the Veterans' Administration furnished the following information:)

The VA is currently experiencing no shortage of nurses in Miami area.

General TURNAGE. We have provision within our system in order to provide incentive pay, pay above the normal going rate, to nurses in those critical areas. We have done that to include, for example, Palo Alto, San Francisco, Martinez, that entire area there, in addition to other urban areas where the nurse shortage is critical.

Essentially, to emphasize the point, across-the-board in the entire country at the 172 medical centers we have sufficient numbers of nurses. In spot areas we are critically short. Moreover, starting next year in this budget we have asked for funds—and it's included in the President's budget—to go back to a nurse training program where by virtue of the training process then they would contract to stay with us for a 1- or 2-year period after that in order to alleviate it.

There are some interesting nuances associated with the nurse situation based on the survey we took. For example, we lose more nurses because of geographic changes, nurses who are married to military or other people who are moving in the society, than we do from the standpoint overall of the failure to be able to meet the local economics associated with the system.

So I would hope that response gives you an indication of the concern that we have about it, but also the fact that we are doing what we can to alleviate it.

Mr. EDWARDS. Yes, that answers my question. Thank you very much.

Thank you, Mr. Chairman.

Dr. ROWLAND OF GEORGIA. Can I ask, Mr. Chairman——

The CHAIRMAN. If you don't mind, we have some members waiting. Later on, if you don't mind. I appreciate it.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

I too would like to welcome General Turnage and his staff and, of course, congratulate Dr. Gronvall. This time VA had the resource and the asset right in its own backyard and decided to recognize him and promote him to that position. General Turnage, you certainly have a tough job speaking on behalf of a budget that is certainly not wholly of your own creation, and I think you know we appreciate that, it is a tough job on your part, and that you do appreciate, of course, our positions.

Sir, you have heard the questioning from Mr. Solomon, Mr. Stump, Mr. Montgomery, and so many others, and we are all known as fiscal conservatives, and yet we are up here basically taking issue with the cuts in the veterans' benefits, certain cuts and whatnot. I think it is very important, and I know you are aware of it, as to why we continually find ourselves in this position. I read some statistics last year. During the 10-year period of time from the mid 1970's to the mid 1980's the VA spending has increased something like 55 percent as against a 126 percent total increase in total Federal spending. So certainly the Veterans' Administration and the Veterans' Affairs Committee have held the line, and that is due to good management on both levels, particularly; certainly, in our committee.

And it is just time that we do not continue to take cuts that are expected from other agencies and other departments that have had these great big increases over the years. I think it is also a point well taken that if other Federal agencies would emulate the model of the Veterans' Administration we would not have near the budget deficits we have today.

Sir, I don't separate a strong national defense from good VA spending, high VA spending. To me they are in the same category. How can we maintain our military strength and a strong national defense, and I refer back to the specific constitutional provision that requires us to provide for the common defense and whatnot, and throw all the money we do into that area and then proceed to cut or rescind, or whatever the case may be, veteran spending? We just are not going to continue to have the high quality of people in the military when they see what we are doing to their parents, if you will, grandparents, whatnot, insofar as our promises to them. I am not sure it is necessary for me to say all that, but I thought I would do so anyhow.

I don't know whether my time will permit me to go into the reduction from 625 beds to 400 in Palm Beach County Hospital. I am sure Mr. Mica will go into that area in great detail. There is also a potential reduction, as I understand it, in the Brevard County project in Florida. Moreover, I have written a letter regarding the nursing home unit in Tampa; this 120-bed nursing home unit. Despite the fact in the most recent fiscal year there was mandated funding, for fiscal year 1987, that was deferred and now apparently this particular budget also doesn't include the funding for that.

In the interests of not being parochial, I am not going to go into that now. We will handle that possibly with our questions outside of this hearing.

I would like to go to the category of medical care. A recision of $75 million has been asked. We spent an awful lot of time here in the change insofar as medical care for veterans is concerned. We basically knocked out the over age 65 and now it goes strictly on income level and whatnot, and we established the category C, I think, Mr. Chairman, with the full realization that those category C people—provided the facilities were available—would be serviced. When you consider the funds for category C, am I correct in assuming, even though I have not been really able to find it in here, that there are no funds—maybe that's why I haven't been able to find it—there are no funds for category C for fiscal year 1988 either?

General TURNAGE. No, sir.

Mr. BILIRAKIS. We have limited funds in fiscal year 1987 for category C people, and we have no funds provided in fiscal year 1988 category C. How in the world—you know, we have sold, those of us who are for this new proposal, we have sold it to our veterans basically with the idea that when the facilities are available they would be serviced. Now you propose to take all the funds out, so we are basically saying to them, regardless, you are just not going to be serviced. Isn't that true?

General TURNAGE. No, sir, it is not.

Mr. BILIRAKIS. I would appreciate—I am past the 5 minutes, but in any case, if the chairman would allow further explanation, I know a couple questions have been asked you regarding that subject, but can you go into a little more detail. I am certainly concerned about it. I am concerned we make promises to our veterans and then we breach those promises.

General TURNAGE. I think in the context of priorities, Mr. Bilirakis, what we are talking about here, is the fact that I enumerated all of the different categories of individuals that came under the category A, entitlement to care are they service-connected and the indigent ones. The ones that can't take care of their own needs were obviously included in that legislation, and I certainly philosophically endorse it and that makes all kinds of sense.

But since July 1st this year with the initiation of the so-called means test, at that time we started getting better data together on the veterans that were being served than any previous time in the history of the program. We found out that some 97.5 percent of those were category A. All others, 2.5 percent, were in category C. The fact is there has been no statement that we would not service category C, and we still intend to do that and we know that some would be serviced even under the provisions that have been provided for or suggested for fiscal year 1988.

The fact is though that because of the vagaries of the system we treat veterans who come to the various medical centers on the basis of resources available, and we still contemplate that some resources would be available for those people that you talked about, although not in full numbers. For example, based on the categories that were established by the Congress, after you take category A and then B, but you go to C, all people who make $25,000 or more, you are really talking about something on the order of 25 million veterans. It is not a practical approach to it from our perspective or from a fiscally responsible perspective either. You simply could not do it.

Mr. BILIRAKIS. But what if those people were 65 and over, had been receiving care or knew they had the right to receive care because they were over age 65, and now we changed the ground rules on them and they are willing to pay for the care——

General TURNAGE. You are talking about 2.5 percent of the total.

Mr. BILIRAKIS. Are you willing to service those people on a space available basis?

General TURNAGE. Yes, sir, and there has been no change in any policy or any support of the program to do that. However, once again, somewhere along the line it seems to us that there must be a line beyond which, in getting that portion of the funding that is available in the competition of all Government agencies, that, as suggested earlier in the prepared statement, we have the biggest budget that we have ever had. We think we can meet the needs of the veterans based on that budget.

Mr. BILIRAKIS. Are you saying to this committee you do not think we should impose a 5 million——

The CHAIRMAN. The time of the gentleman has expired. Let's give the other members a chance, and I will come back and give you part of my time.

The Chair would like to recognize the gentleman from Alabama, Mr. Harris, a new member of the committee.

Mr. HARRIS. Thank you, Mr. Chairman.

Gentlemen, I look forward to working with you as a new member from Alabama. We have a VA hospital in my front yard in Tuscaloosa almost, so it is a subject I am very interested in.

General TURNAGE. Mr. Harris, I visited that hospital, and I think it's an excellent one.

Mr. HARRIS. Thank you. We are proud of it.

Two things, I guess one good, one bad. I want to compliment you for reactivating the health professional scholarship program in the budget. I think that is good because I have a feeling maybe we are losing some personnel as a result of the program not being activated. But one thing that is of concern to me and other people that have talked to me is the proposal in the budget for a revenue enhancement measure to increase the funding fee that is paid by veterans to obtain a VA guaranteed home loan. I would like to hear from you a little bit on that. We are very concerned about that, and there is a feeling that the VA people are being singled out for this revenue enhancement measure.

General TURNAGE. John.

Mr. VOGEL. Thank you, Mr. Administrator.

Mr. Harris, we have made a projection of what our obligations will be and what our revenues will be through 1992. We would have had to ask the Congress for over a billion dollars in appropriated funds from the revolving fund. To obviate the need for appropriated funds, we have determined that the 2.5 percent funding fee will make the program self-sustaining. That will, in fact, raise, as the Administrator mentioned earlier, the average veteran's mortgage payment on a $75,000 loan about $9.50. They can finance that in their mortgage. We think that is a prudent thing to do rather than to seek the funding from the revolving fund.

Mr. HARRIS. It is my understanding from what you say it would take those additional monies to make this particular program self-sustaining?

Mr. Vogel. Yes, plus the continued sale of VA and other loans together will keep us in a position of not having to request appropriated funds for those loan programs.

Mr. Harris. Thank you.

Thank you, Mr. Chairman.

The Chairman. Thank you.

The gentleman from Illinois, Mr. Davis.

Mr. Davis. Well, thank you very much, Mr. Chairman; and to the ranking member, Mr. Solomon, I appreciate your introduction of General Turnage. It's a pleasure to be on this committee, for the record, to be able to serve with the distinguished members of the committee and to serve the country and the veterans who protected her over the years.

Most of my questions, General Turnage, are parochial in nature and reflect my State's and subcommittee's desire to hear the answers, and I will submit them in writing to save the time of the committee.

But there is one general policy question I would like to take up, probably with Dr. Gronvall rather than you or maybe both since it seems to be a policy question or it, at least, appears to me to be that way.

You are even to be congratulated or condemned, I suppose, or maybe a little of both for the answer to this question, and I am just curious if it is philosophical or if it is medical or if it is a combination of both.

The average hospital stay in a VA hospital has dropped dramatically 15 percent in the last 3 years. Is this a concerted effort on the part of the Veterans' Administration hospital staff and policy to lower the number of days of care in terms of cost cutting? Philosophically it seems to be the case in private industry, anyway, that is going on and in the States in hospital care. Is this a philosophical attempt on the part of the Veterans' Administration to review the utilization of beds in the hospitals and to limit the amount of stay? Are there medical reasons for so doing? What are the answers to these variety of questions?

Dr. Gronvall. Mr. Davis, I would hope that your questions would all be on a note of congratulations because I think the changes that we have made are appropriate, actually, on all of those grounds—medical and economic, and the most effective use of resources.

Once again, the medical care patterns within the Veterans' Administration tend to mirror what is going on in the broader medical community because we are a part of the broader medical community; and as you well know, many of our physicians serve not only in VA hospitals but in other affiliated hospitals.

Over the past several years we have made a concerted effort to align the incentives for our hospitals, and by that I mean not only the physicians but the other professional staff and the administrative staff, to most effectively get the patient admitted, make a diagnosis, get the treatment carried out and get the veteran patient back out of the hospital and back to a useful, productive life. We have done that in a number of ways.

Very specifically, our funding model for our hospitals, the so-called resource allocation model using diagnosis related groups, a process similar to what is going on in the private sector, has created a direct incentive to get the patient in, diagnosed, treated, and out of the hospital rather than having the inappropriate incentive which has existed in the past of just keeping the beds full and letting the patient linger on in the hospital.

At the same time we have tried to watch very carefully to make certain that no one is short cutting the care of any individual veteran patient. We have quality assurance reviews. We monitor hospital utilization to insure that our veteran patients stay in the hospital as long as they need to be there. But, in short, we have been able to treat more veterans with the same number of beds, in fact, a declining number of beds, by being able to get the patient in and out of the hospital more quickly and concentrate our medical care efforts.

So, I believe that represents a success story. I think that trend is going to continue on, at least for the next several years. There are some factors that will mitigate against it, and we could discuss those if germane, but it has been a conscious effort in the VA and in the entire hospital and health center.

Mr. DAVIS. One follow-up question.

As it continues to decline, is there an announced or unannounced policy of the VA within the DRG philosophy you just espoused to continue to reduce the number of days when appropriate?

Dr. GRONVALL. We have not created a specific objective to reduce the length of stay to any specific level. We have tried to create a set of incentives.

Mr. DAVIS. Is there a target?

Dr. GRONVALL. There is not a specific target. We have tried to create an incentive. But our goal is to deliver quality care in as short as possible time in the hospital, and we don't have an artificial target of a working order.

Mr. DAVIS. That serves a laudable goal, one we all seek. That is the end result.

If I asked the veterans' organizations that same question, would I receive roughly the same answer?

Dr. GRONVALL. They, of course, have to speak for themselves, but we have had very few, if any, assertions that we are discharging patients too early.

Mr. DAVIS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. The gentleman from Indiana, Mr. Jontz.

Mr. JONTZ. Thank you very much, Mr. Chairman.

I, like the other new members of this committee, am looking forward to working with you gentlemen and very much appreciate the good work you do on behalf of the veterans of our country.

Reference was made a few minutes ago to the VA facility under construction in Crown Point, Ind., which is in my district. I am very appreciative, as was my predecessor, Congressman Hillis, and all the residents of our area, of the fact that the VA has been willing to locate that facility there. I am even more appreciative after hearing the gentleman from New Jersey today talk about their problems.

However, we do have a small problem in Indiana, as you are aware. The Department of Labor has made a ruling and determined that the Crown Point facility should be constructed under the provisions of the Davis-Bacon Act, and the VA has seen fit not to abide by that particular ruling. I want to ask today why the VA is not following the Department of Labor ruling with regard to the applicability of the Davis-Bacon Act to this particular construction project?

General TURNAGE. Mr. Jontz, our counsel is well versed in that particular issue. Let me ask him to respond.

Mr. IVERS. The Veterans' Administration takes the position that Davis-Bacon wage rate provisions do not apply to lease agreements. That is a position that has been upheld by courts. It's been upheld by GSA, been upheld by the GAO. This ruling from the Labor Department is the first of its kind in over 30 years of experience in leasing by the Government. We now have that decision on appeal in the appropriate forum, which is the Wage Appeals Board in the Department of Labor. That determination has yet to come forward. So at the present time it is an open question in the eyes of the VA.

Mr. JONTZ. I might add, Mr. Chairman, that this dispute is causing a great deal of difficulty in our community and creating a very, very bad situation there. Perhaps I am misinformed, but it is my understanding that it was the responsibility of the Department of Labor to make those sort of determinations. In light of their ruling, I am a little bit confused as to why you are continuing to proceed as if they had not made that ruling.

I would ask that you reconsider your decision because it is causing many, many problems, and I find that unfortunate because we are very pleased to have such a facility located in our community. Furthermore, I would ask that you change your position based on the fact that these problems are occurring.

Mr. IVERS. Not at this time, sir. This, as I say, remains an open issue. It remains on appeal. We take the position that the lease agreement that was entered into there does not include Davis-Bacon wage rates. There are no grounds to change it at this point.

The CHAIRMAN. The gentleman from New Hampshire, Mr. Smith.

Mr. ROBERT C. SMITH. Thank you, Mr. Chairman.

I also, as a new member of the committee, and a veteran, welcome you and appreciate the work that you do. I just have one quick question.

In my State, and I don't really have a reading in terms of what is going on in other congressional districts around the country, there is the perception by veterans' groups, and to some extent that perception is supported by the case load that I have seen in the last 2 years as a Member of Congress regarding veterans' matters, that disability requirements are looked at sometimes in a discriminatory manner in terms of reducing the disability from, say, 100 percent to 70 percent for a particular veteran because of budgetary cutbacks. I realize that is a harsh question, and I guess what I am asking you is, first of all, I am hoping that is not the case as a policy of the VA. Secondly, what is that policy? Do you at any time ever direct your agencies to simply re-evaluate or reopen disability cases of veterans simply because of the budgetary constraints?

General TURNAGE. There is no relationship between the two, sir. There are re-evaluations that go on on a continuing basis, and some of which have been directed by this body here and some of which have become quite contentious; but any perception that exists according to that is without fact because what we do, if there is any question of benefit, it goes to the veteran in each case.

But with regard to specifics about the benefit program itself, I have asked Mr. Vogel to further elaborate on that response.

Mr. ROBERT C. SMITH. Let me make one point before you do. You would certainly agree there would be no quicker way to stir things up in terms of getting more funding back than to do something like that. I am not accusing you of doing it, believe me, but the perception is there that this does occur. In some particular individual cases that I have seen, a person who has extreme mental disorders as a result of combat service, who has been on a hundred percent disability for 15 years and suddenly he is dropped to 70, you know, with no new medical information. I have seen it, and I have been told by officials who remain nameless that, well, budgetary constraints caused it.

I am just saying this is a very serious matter in terms of the perception out there, and I think it needs to be at least looked at within the agency.

Mr. VOGEL. Mr. Smith, I can assure you that the individuals who perform the very valuable task of evaluating the degrees of disability are never, and never shall be, placed under any kind of caution or whatever with respect to the budget. We provide the compensation and pension benefits based on the degree of disability. They do so purely on that basis.

You have indicated cases of a veteran with a 100-percent neuropsychiatric condition going to 70 percent without medical evidence. We never would change an evaluation without an evidentiary basis for doing so. The only time that we ever re-evaluate any veterans, whether 10 percent or 50, or 100, is if there is a medical judgment that there is a likelihood of improvement in the condition. When a condition is stabilized or the condition is such that there can not be and will not be an improvement, we provide the compensation. We never examine him again. For the rest of his life he would draw that benefit.

But I just reiterate we would never change an evaluation without some evidentiary basis for doing so. If you have any specific cases I would be pleased to look them up, but I would imagine from time to time it is difficult for a given individual to understand why a 100-percent evaluation became a 70 percent. The fact of the matter is, it is based on a medical judgment that there is, in fact, an improvement in the condition, in large measure a reflection of the quality of the medical care in drugs and other treatments that can be brought to bear for that given disability.

Mr. ROBERT C. SMITH. Thank you, Mr. Chairman.

The CHAIRMAN. The gentleman's time has expired.

The gentleman from Minnesota, Mr. Penny.

Mr. PENNY. Thank you, Mr. Chairman.

I have several questions. I will keep the questions short and hope if you can keep the answers short we can get through them all.

I wrote you a letter recently, General Turnage, on beneficiary travel. I am concerned we might be boxing veterans out of parity by not providing beneficiary travel. Have you done an analysis of this issue in terms of the increased costs for fee basis care as opposed to the cost of travel?

General TURNAGE. The interface between fee basis care as opposed to the cost of beneficiary travel was one of the facts considered in the overall analysis. We know that fee basis is more expensive than beneficiary travel. In the regulations that are being published, we are very conscious of the fact that some 97 percent of the veterans in the country live within 100 miles of a major medical center, and what we are trying to do is husband the dollars that are available to us to put in the most effective place, and we think that it is more effective to be used for medical care, for example, as opposed to some of the travel situations before.

What we are trying to do is not only trying to take care of people on a priority basis, that is to say, both those who are higher priorities and so forth, but also we are putting, in effect, a radius beyond which everyone will still continue to get the travel considerations. We have gotten some input, very effective input from the veterans' service organizations, and we think we have a reasonable approach to it now.

Mr. PENNY. I do have a strong concern that we might, by denying travel, put some veterans in the position where they get no care at all, and that is not the situation we want to see. So we would like to continue to work with you on that issue.

General TURNAGE. I understand.

Mr. PENNY. On medical care, I see you got a $414 million increase over last year's funding; but if we were to go with current services, what would the increase need to be?

Dr. GRONVALL. It would be higher than $414 million.

Mr. PENNY. Do you know the amount?

Dr. GRONVALL. The technical definition of the current services figure for 1988 has been something discussed recently. I am not trying to be vague on it, but I don't have a specific figure that I could give you. But we could supply it for the record.

[See p. 166.]

Mr. PENNY. It looks to me that we are talking about $300 million more than what you are requesting. I wanted to make sure that in the context of today's hearing that was brought forward. When you propose an increase, it is still estimated to be $300 million shy of the current veterans' services funding.

You don't have any new construction. I do want to say I appreciate what is going to happen as part of the new medical facility in Minnesota. We will have some nursing home beds in that facility, but you don't have any other new construction for veterans. Yet I do not see anything more than a very modest increase in State grants, so I don't see the trade-off occurring there. There is a dramatic need for nursing home beds across the country.

Dr. GRONVALL. To try to get a short answer to that, you will recall the new strategy we announced a year ago, increasing reliance on both State homes and community nursing homes. A year ago we did approximately double the budget support for grants for State homes, and the budget proposal for 1988 continues the State grant program at that higher level. So that is a reflection of continuing that strategy.

Mr. PENNY. The next few questions I have relate to outpatient clinics in the budget, particularly the proposed facility at Duluth. Is that site pinned down?

Dr. GRONVALL. I cannot answer off the top of my head. I believe the specific site has not been identified.

Mr. HARVEY. The outpatient clinic for Duluth or Superior is presently under consideration. An area in each community has been identified within which a facility would be acceptable and responsive to our needs. I am not sure—perhaps Susan Livingstone, the Associate Deputy Administrator for Logistics, could respond. Once proposals are submitted either for lease or construction we will be in a position to determine specifically what facility will be appropriate to pursue in those areas.

Mr. PENNY. Thank you. I see my time has run out. I had a question on the annual proposal for the consolidation of the St. Paul and Philadelphia insurance centers. I will get to that privately, and I am also interested in an analysis of what we are going to do with Building 43 on the Minneapolis VAMC campus now that the new facility in Minneapolis will be activated. I was supposed to hear from you folks in November about the plans for Building 43, and I haven't heard. We will pursue that after the hearing.

The CHAIRMAN. The time of the gentleman has expired.

The gentleman from Connecticut, Mr. Rowland.

Mr. ROWLAND OF CONNECTICUT. General, I also would like to join my colleagues in welcoming you here this morning along with your staff. I also look forward to working with you again. I just have one simple question that seems to be creeping up as a problem in my State.

We have had a number of problems with staff turnover in one of our VA hospitals, and knowing full well that my State has a very high per capita income and a great deal of competition with the VA hospital, would you or someone from your staff make a few comments about the so-called special rate structure. We have had instances, not so much with lab technicians at this point because there has been some consideration, but certainly with pharmacists, where we have not been able to keep a pharmacist on for any length of time and they keep turning over to the private sector. We talked about the special rate procedures, and I was wondering if you could familiarize myself and my colleagues with that.

Dr. GRONVALL. I can give you a quick answer, and we would be pleased to supply any amount of additional detailed information; but as a generalization, the specific pay rates or special pay rates are intended to keep the VA salary schedules more comparable or competitive with the private sector in the geographic area in which the pay is being given. So our individual medical centers can request from Central Office authority to pay special pay for a number of categories of health professionals. Those proposals are reviewed in Washington. The data that support the proposal, pay rates in the community, etc. are evaluated; and when the pay rate is approved, then the salary rates at the VAMC can be increased.

Responding to the personnel shortage that was being discussed earlier, in the past 4 months we have accelerated our process for receiving, reviewing and acting on special pay rate requests. For example, just in regard to nurses, we think that during this year, 1987, we will probably approve something on the order of $20 million of special pay additions to our total nursing payroll. So we are working hard to try to keep our salaries competitive. Unfortunately, we find some specific areas where, for one reason or another, either shortage of people or very rapidly escalating salary levels in the private sector, we fall behind the curve.

We are taking the steps earlier to try to stay competitive because our goal, of course, is to have a high quality work force in the various health care occupations we need to provide the care.

Mr. ROWLAND OF CONNECTICUT. I take it you have enough budget authority within those discussions to try to make sure you can meet those ends. Are you finding now as you make adjustments, and you are probably feeling this across the country, that you are having the dollar limitations as you try to make those commitments?

Dr. GRONVALL. We have the authority that we need to rearrange the funds within our budget to pay those special rates. Basically it means, of course, taking the funds from some other category where they would have been used. But we have all the authority we need to make those decisions within the VA, yes.

Mr. ROWLAND OF CONNECTICUT. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. The gentleman from Pennsylvania, Mr. Kanjorski.

Mr. KANJORSKI. Thank you, Mr. Chairman.

General, I guess I would like to follow up on something Mr. Penny talked about, specifically that you have recognized in your testimony today there is a significant change in the need for benefits for veterans over the years and particularly now we look at the nursing care centers. I notice in your budget there are no provisions for any additional nursing care facilities in the United States whatsoever. Is that some new moral we have arrived at that we no longer have nursing care needs?

General TURNAGE. No, sir, not at all. I am sorry that is a perception or the impression. The fact is that there are a number of initiatives ongoing now to accommodate the additional need for nursing homes, including the fact that we have this incentive where we are trying to interest States in coming up with the State veterans' homes; and in your State, for example, we provide such support. We provide 65 percent of the cost of a new State veterans' home, plus provide a per diem for each eligible individual who is domiciled there over the period of time he is there. But that is one way.

The second way is we are taking steps now where in so many of our medical centers we find beds are vacant simply because the demand for inpatient care is less. We are going to a program of converting some of those to nursing home beds. We also have in conjunction with that the need for more people within domiciliary areas or within the community nursing homes. There has also been a substantial trend, not only in our system but in the private sector, for people to use outpatient as opposed to inpatient type facilities in the system. We do have certain nursing homes now that are under construction, that will be finished during fiscal year

1988, and we project that in the future we will continue to have nursing homes. The question so often asked is where and to what capacity and so forth.

Mr. KANJORSKI. The converting of existing beds, wouldn't you agree, in some instances that is inappropriate where a hospital is already filled with the beds necessary for immediate care?

General TURNAGE. I am suggesting only in those cases where you have space available to do that. For example, in some hospitals we have wings that are not being used now because the inpatient load is not sufficient to require it.

Mr. KANJORSKI. In those areas of the country, and I am particularly looking at Pennsylvania where the population is getting elderly and we still have the full demand for the hospital beds, the provisions that you are taking, it seems to me, contracting out services and trying to convert beds, from what I understand from the officials in Pennsylvania there are not any beds to convert in many instances. So we are stuck with putting these people out for 6 months and the VA no longer has a financial obligation.

What I am wondering is have you looked at the statistics in these areas? I noticed in the Wilkes-Barre Hospital we have a 2-year delay; we have over 225 veterans on a waiting list for more than 2 years to get into a 60-bed facility. Do you think that is an appropriate length of time to allow a veteran to lay around for nursing care?

Dr. GRONVALL. Susan Livingstone, the Associate Deputy Administrator for Logistics, could speak to the specific details of the Wilkes-Barre facility.

Miss LIVINGSTONE. The design for the 60-bed nursing care unit at Wilkes-Barre has been completed as of last October. The difficulty is that there has been a limit on nursing home projects, given budgetary limitations.

I might remark in our fiscal year 1988 budget there is a net gain of 370 plus nursing home care beds in the system. Most of those are obtained through conversion, such as a 170 bed net gain in Chicago and also a 12 bed net gain at Pittsburgh.

Mr. KANJORSKI. You will agree the intent of the Congress for the last 3 years is to appropriate funds to have a facility built in that area and funds have been expended to design that facility, and the intention of Congress was in 1988 and the statement of the Veterans' Administration was 1988 was the construction year. We look in the budget and there is no longer the construction money there; and, obviously, therefore, do we recognize there is still the need, but we definitely decided not to build that facility because we cannot afford it?

Dr. GRONVALL. The issue of need and program priorities, of course, is a nationwide judgment. I referred to the revised strategy that was developed a year ago that does place greater reliance on the State-owned program and the budget for State programs.

Mr. KANJORSKI. I like that program, but we have to admit that is 3, 4 years down from the beginning of inception to construction; and since we have a waiting list of 400 percent of the beds available in this one veterans' hospital, I guess by attrition we will solve our problem.

The CHAIRMAN. The time of the gentleman has expired.

Would you like to respond?

General TURNAGE. Can I specifically submit it? We have someone looking at that in more detail, and I will get back to the Congress specifically about that.

[See p. 167.]

Mr. KANJORSKI. May I have my remarks put in the record?

The CHAIRMAN. Without objection, so ordered.

[The prepared statement of Paul Kanjorski appears at p. 169.]

The CHAIRMAN. The gentleman from Illinois, Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

I want to welcome you and your staff before the committee and compliment you on including $2.5 million in women's epidemiological studies in the budget. That is an improvement, but I do have some concerns as well. I want to comment on what I view as the continuing ill-advised reduction of the funding for the State approval agencies. Between fiscal year 1986 and your recommended fiscal year 1988, the SAAs have been reduced 30 percent. In your budget document you justify that reduction by pointing to the anticipated decrease in pre, post and supervisory visits consistent with declines in work load.

Chapter 34 patients who are declining individual training under the New GI Bill will be significantly increasing. Your budget document shows 433,100 trainees in fiscal year 1988. It is my view any further revisions in the SAA budget will poorly serve our veterans who are using the New GI Bill. So I would appreciate it if you would provide me with a thoroughly detailed justification in the budget request for the SAAs. I would like a State-by-State breakdown of projected program participation, including those training under chapters 30, 31, 32, 34, 35 and 106 of title X. I would also want a State-by-State projection of participating institutions. I understand from the State approval agencies their information shows significantly more trainees in institutions than compiled by the VA and would appreciate that if you could get that to me in a matter of due course.

General TURNAGE. We can do so.

Mr. EVANS. For the next fiscal year the VA is requesting $6 million to reactivate the health professional scholarship program to support 211 1-year and 84 2-year awards to nursing home and physical therapy students, but for the current fiscal year the VA requested no funding for that scholarship program. Reactivation of the program is being proposed, according to the budget, because "in some areas the VA is again experiencing recruitment difficulties in nursing and physical therapy, particularly in specialty fields such as geriatric nursing."

Could you elaborate on the nursing and physical therapy recruitment difficulties being experienced by the VA? Specifically is there a shortage of nurses in the VA? What is the magnitude of this shortage? How has this shortage existed?

General TURNAGE. Yes, I can do so. Would you like that for the record or separate to you or how would you prefer I respond?

Mr. EVANS. I guess I would appreciate it in more detail for the record, but a general response could be given now.

[See p. 173.]

General TURNAGE. All right. Prior to your arrival, sir, this question was asked by the chairman, and I tried to point out that across-the-board, based on data which is as current as the last 60 or 90 days, we found that overall there is no nursing shortage within the VA system. With certain specific areas of the country, there are grevious nursing shortages in the country. Most of that relates to the economics. For example, we have shortages in the greater San Francisco area, shortages in the L.A. area, Miami area, New York area, and so forth. But from the standpoint of absolute numbers, it is a matter of displacement or having them in different areas than we would like to have them. Economics plays a great role in it. The fact of just simply geographic moves have an impact. That is the greatest factor for causing us to lose nurses in our system as opposed to economics. We have a normal attrition.

(Subsequently, the Veterans' Administration furnished the following information:)

The VA is currently experiencing no shortage of nurses in Miami area.

General TURNAGE. The fact is some of the specific types, particularly in the areas of therapists and so forth, we have an ongoing problem and that is why we reinitiated this system for fiscal year 1988.

We have discussed this with Dr. Gronvall and he has initiated steps to start the program very early in fiscal year 1988.

Mr. DAVIS. I understand you have done a survey on nurses throughout the system.

General TURNAGE. We have.

Mr. EVANS. Are you going to submit that for the record?

General TURNAGE. There is no reason why we should not do so. It is going to be for the public domain, so we will be glad to provide that. In that survey now, there are about 12 or 14 different job specifications, professionals, in the system that are being reviewed. We have finished the review of about half of those. The other half is in the works now, and we would be glad to provide you that as soon as it is completed, and we don't expect it to be a long period of time.

[See p. 173.]

Mr. EVANS. I have a number of questions I would like to submit.

The CHAIRMAN. Without objection, the gentleman will submit them for the record and the Administrator will be happy to answer, I am sure, to respond in writing.

The CHAIRMAN. The gentleman from Florida, Mr. Mica.

Mr. MICA. First I would like to say I support the comments by my colleague from Florida, Mr. Bilirakis, and say we do have some problems in Florida which I will allude to in a moment, but I would also like to say welcome, gentlemen. We are glad to have you here and I see an old friend, Tom Harvey. I look forward to working with him.

General TURNAGE. If your questions are contentious, he can answer those.

Mr. MICA. You remember earlier in the hearing you mentioned that we are dealing with a moving train. You know what State that train is moving to, and how many veterans a month are on that train. I bet the chairman knows. California and Florida, and

Arizona, there are 4 or 5 States that are having a phenomenal problem. We want 60 straight months, I don't know the current figures, 60 straight months, 5 years, with 5,000 veterans a month moving into the State of Florida. Now, I think you are aware of our new hospital, and the problems we are having financially trying to fit it over the ground in West Palm Beach. We are looking at something over three other hospitals in the State of Florida.

You authorized that study some 8 years ago, we thought it might show that Florida needed one new hospital; once it was completed it showed that Florida needed four hospitals and two or three outpatient clinics and now I see in the newest budget that the hospital is still there, but it has been reduced from 625 beds to 400 beds, and reducing the nursing home care beds and I would say, General, these are questions that I would like you to ask your staff.

I think maybe there is some bad advice or bad figures here. We are reducing it and they are indicating that there is not the need.

A couple quick statements. My congressional district, like all in 1970, was 435,000. In 1980, it was 1.1 million. In other words, they cut 600,000 out of the district just to make it the size of everyone else. Now, today, we started out in 1980, with 512,000 people, and my district is close to 900,000. We will probably be 1.4 million by 1992.

We are dropping the number of beds. Florida, our State, is expected to get at least four new Congressmen and some say as many as seven or eight in 1992. Now that is 2 million new residents. We have had all of this, and not a single new hospital bed in Palm Beach County, in fact none. So, the need is there; one-third of the district that I have is over the age of 65, one of the highest population rates in the country, one of the oldest in the country.

And then they come in and say to you, or whoever is presenting these statements, that the need really isn't there. Every State agency and private group that has researched nursing home care beds in Florida says we have a freight train coming down the track that is a crisis, and here the VA is the only one of a dozen that comes in and says, "we don't really even need that."

So, I just ask you, I would like to have the statements that were submitted to indicate that we don't need this hospital, this number of beds and we don't need the nursing home care. I would like to have the records, the reports and the statements that were submitted and I would tell you that I think we can very efficiently and correctly counter any misinformation that you have had. The rest of the State is just about in as bad shape. Throughout the balance of the United States as a veteran, you can go in and get care just in any category. In Florida, it has been years since we have treated the nonservice-connected and category C. We have a real difficult problem. So, I just ask for your consideration there, and ask that you ask these questions.

I would like to personally visit with you. I won't take any more time on the committee, but it is a serious, I think, situation of misinformation. Inappropriate information, and I would like you to look at it. One question, aside from a parochial interest: Washington, DC, recently closed down its cardiac surgical care unit, we had major national attention focused on Miami hospital, and hospitals around the United States. I think it would be appropriate to release as much information as possible to the public, the reports keep coming out that VA is being overly secretive. We are not a national security agency. Wherever and whenever we can give as much information as possible, I would hope we will, and maybe you have a comment on that.

General TURNAGE. Just two comments, sir, in response briefly.

One, our concerns about the Florida situation haven't diminished at all. However, speaking of the moving train, there are a number of other factors to include medical technology, the ages of the veterans, the impact of the lengths of stay—a lot of factors went into the hospital consideration there. But in addition to Palm Beach we still haven't changed our attitude about the facility. There will be a hospital either in Orange or Brevard County, eastern central Florida. We have projected there will be one somewhere in the Panhandle. We recognize what is coming down the pike. I share your concern that we want to do something about it. Where you may be help to us is, for example, where we have the initiative of being able to support State veterans homes. We would be glad to do that in Florida, too, to the tune of providing 65 percent of the cost plus a daily per diem for the people who are in it but we have none of those in Florida, I think, that is a State initiative that would be helpful.

Mr. MICA. Mr. Bilirakis and I can visit with you at a later time. We would like to do so.

General TURNAGE. With regard to the heart surgery situation, we have some 52 places in the country where we provide cardiac surgery. We have a continuous review on those all of the time. In some cases, we found that all of the criteria we desired for the continuance of quality care that were necessary for us to continue those programs weren't present nor was there a projection that they might be. In those cases, in the interest of quality care, which to us is the very highest priority, we determined that four would be terminated. That doesn't mean that sometime in the future they may not be considered, but there is nothing secretive about the process. It was a management decision based on the dedication that we have to quality care for our people.

Mr. MICA. Thank you.

Mr. EDWARDS [presiding]. Time has expired. The gentleman from Ohio, Mr. Applegate.

Mr. APPLEGATE. Thank you, Mr. Chairman. General, it is good to see you. We had a very pleasant meeting the other day. And I enjoyed that. It is good to see you and your very capable staff before the committee.

All of you, and of course I guess I am a little closer to seeing John Vogel more than anybody else individually, but I also want to congratulate Dr. Gronvall for his moving into the position that he is in. It is a very valued position and with his background I am sure that he will do it great justice.

Dr. GRONVALL. Thank you, Mr. Chairman.

Mr. APPLEGATE. To Dan Mica, I know he also talked about 5,000 people moving, and I know that a great many of those come from Ohio.

Mr. MICA. We will move his facilities to Florida also.

Mr. APPLEGATE. That is a two-way street, but I know one time, and Marcy Kaptur can verify this, going into Florida on Interstate 75 I went in one time and saw a big sign "Welcome Ohio, Keep Florida Green".

So I know that Ohio is taking the money down there.

But I will do this very quickly. I have just two questions, perhaps not questions I have, no real parochial interests, I don't have any hospitals, in-patient or out-patients, don't have any cemeteries, but I do have thousands upon thousands of veterans, who are dependent upon the Veterans' Administration and who look to me for guidance.

Two questions, that I have, happen to be within my jurisdiction, as chairman of the Subcommittee on Compensation, Pension and Insurance, and one of them is that I know, General, with regard to legislation that is being proposed to index compensation benefits, that is going to be one that I am definitely going to oppose you on. I know that you have to carry the administration legislative package, so whether you feel that you are personally supportive of that or not I don't know, but we will talk about that another time.

The only thing I would apply to that old adage "if it ain't broke, don't fix it," and I like to keep the jurisdiction within our confines.

I wanted to ask you that in your goals for general operating expenses, that there is a reduction of the staff in the adjudication division, 45 in support services, 95 in veterans services. That means there will be 350 less man years available for direct service to the veterans, that much less than there was last year.

I just wanted to ask you, how the Veterans' Administration can justify this substantial increase when as I understand in your own estimate, that they show that compensation, pension and education original claims will increase and supplemental claims will only decrease very slightly. Even if your workloads were to decrease, how can you justify reducing personnel when none of your adjudication division are meeting timeliness standards today?

Mr. VOGEL. Thank you, Mr. Administrator. Mr. Applegate, in the last few months we have been installing in all our regional offices, an office automation system which will in fact give us some greater capacity in handling the clerical duties that are attendant to the examination of loan applications, and the adjudication of compensation and pension cases. We expect to achieve some personnel savings and productivity increases through the use of that system. We are moving ahead with modernization, especially in the loan guaranty area. It has been a challenge to handle that workload during the last year. The slippage that we have had in the timeliness of various categories of cases is a matter of significant concern. We see some improvement in the last few months. Part of our workloads are in fact going down. The education programs are down markedly, and pension is down. We certainly intend to do the very best we can to continue to provide the very best service.

Mr. APPLEGATE. Thank you.

Well, I thank you very much for that, John. I want you to know that my subcommittee will be holding oversight hearings to review the timeliness and the quality of the DVB service to the veterans. That is when we get into the real nuts and bolts of why it has taken longer for regional offices to handle the claims. We can talk about that at that time.

That is really all I have to ask right now. Many of the questions that were of concern I think have been asked, I don't know whether the General has wanted to make any comments on the first one or not, but, if you don't, I will talk to you later about it. That has to do with the indexing of compensation benefits.

General **Turnage**. Simply to say, Mr. Applegate, that not only confined to the veteran benefits area, but in memorial affairs and in the Department of Medicine and Surgery and in the system overall we are enhancing the automation systems to the point where we think that we should be getting productive benefits there as a result. We have no design to reduce our working staff unless we can justify that it makes sense to do so.

I think it is consistent with what John has said and we hope that in your hearings we will be able to give you the definitive information to you about——

Mr. **Applegate**. I guess the question was, if you had any comments on the proposal to index compensation benefits.

Mr. **Edwards**. We would prefer the Administrator provide those in writing.

Mr. **Applegate**. That is fine. If you would you don't have to answer that now. We will be holding hearings on that but I would like to have at least a written answer on that.

(Subsequently, the Veterans' Administration furnished the following information:)

It has always been the VA's practice to recommend periodic adjustments in monthly compensation rates as the economic conditions change. In recent years the Congress has keyed the compensation adjustments to the indexed cost-of-living adjustments (COLA's) for social security. These periodic adjustments have not been automatic as legislation was required each year. Indexing the rates to social security COLA's would assure automatic and timely adjustment while at the same time removing the increase from the legislative process.

The rates under our pension programs are increased based on social security COLA's. If this proposal is implemented the rates of compensation would be adjusted periodically based on a standard methodology (social security increase) which would insure that the service-connected veteran would not receive a smaller increase than other recipients of government benefits. The increases also would occur at the same time, thereby preventing the service-connected veteran from having to wait longer than other recipients.

Mr. **Edwards**. The gentleman from Texas, Mr. Stenholm.

Mr. **Stenholm**. Thank you, Mr. Chairman. I understand that the question that I would have asked has already been asked and addressed by the chairman earlier today. I would just like to underline my concern along the same line, but for a few different reasons than the gentleman from Florida, Mr. Mica, just expressed. I represent a rural area of Texas, there are some 33,000 square miles in my district. The Big Spring VA facility serves some 50,000 square miles of veterans. We have a tremendous health problem in rural America. A problem I would rather call an opportunity, because I think the challenge that we in the Congress and those who are in charge of delivering health care have to face, is going to be to answer the question of how we deliver health care to the veterans who are choosing not to move to Florida but rather moved back home after serving their country and have no desire to leave.

They intend to die in that area that they fought to preserve.

The question is the mission change, and how we provide health care that those individuals deserve as well as serve those in the more populated areas.

Again, I don't have a question today except to really and truly emphasize my concern and to underline my support of what I understand the chairman earlier expressed. His desire to investigate further before proceding with mission changes. In Texas we have had many rural hospitals close, four in my district, some five to ten in my district that are very valuable are in serious danger of closing. I see a great amount of similarity in the problems facing VA and rural Health care providers and quite frankly that was one of the major reasons that I chose to make a committee change and join the Veterans' Affairs Committee. I think answering the question of how we provide the care to rural veterans, that they deserve, within the framework of budget confines, will go a long way toward answering the question of how we deal with the citizenry as a whole. So, Mr. Chairman, I have no specific question, except to just say that I think we have a real challenge here that we need to look at in depth and I welcome the opportunity to work with you and the chairman and other members of the committee in trying to come up with an answer to that.

General TURNAGE. Please let me endorse a simple fact, I have shared the same sensitivity about this issue, we don't make decisions in the vacuum nor will we make decisions which we consider to be prejudicial to the overall system or to the veterans, sir.

Mr. STENHOLM. That I appreciate and look forward to working with you.

Mr. EDWARDS. The last member to be recognized today is the new Chair of the Housing and Memorial Affairs, the Gentlewoman from Ohio, Miss Kaptur.

Miss KAPTUR. Thank you, Mr. Chairman.

I apologize for being a little late. We had planes in Ohio taking new residents down to Florida this morning and there were more of them than of us, so I apologize.

I wanted to recognize General Turnage and welcome you to our committee. For the first time I have actually had an opportunity to meet here with you formally. It is better than running into you in an elevator. I also wanted to congratulate Dr. Gronvall and also thank you and recognize you for the assistance that you have given us in improving the services at our veteran's out-patient clinic in Toledo, Ohio.

Considering the budget constraints under which you are operating, the attention that you personally have given your staff at the clinic, as well as the work done by the folks up in Ann Arbor, have made major improvements and I hope that that continues. It is markedly better than 2 to 4 years ago.

Dr. GRONVALL. I appreciate that comment very much and we intend to maintain strong support.

Miss KAPTUR. I don't get complaints like I did before and I thank you.

I wanted also to thank the chairman for recognizing me and for the record I just wanted to affirm my commitment to the continuation of the VA Home Loan Guarantee Program as well as the cemetery program, and before my colleague, Mr. Mica, walks out I would like to tell him that, in the memorial affairs budget, there is a cemetery program for the State of Florida.

Mr. MICA. We need that, too.

Miss KAPTUR. In looking over the VA's budget document I noticed that many of the housing proposals appear to be moving away from operating programs as a veterans benefit. I don't mean to indicate that the program shouldn't be run as efficiently as possible, but I think that we should bear in mind the original purpose of the program and the fact that it is an earned benefit. Along those lines, I have several questions, many of which I will submit for the record and try to get some of them in here this morning for direct reply.

When the Congress enacted the 1 percent user fee, it bore a responsible relationship to the administrative costs of servicing loans. Don't you agree that a 150 percent increase is a tax rather than a servicing charge on the veteran?

General TURNAGE. Miss Kaptur, when you say 150 percent increase, I think it gives the wrong inference quite frankly. Here I can recognize we have some trade-offs that we have to consider. Just a few years ago, 5 years ago, when we had 17.5 percent interest, an individual who had a 30-year conventional loan for $70,000, for example, was paying upward of a thousand dollars a month for that mortgage. Now, under the 8.5 percent that we enjoy today, he pays something on the order of $530. Now, if we go with this increase that we have suggested, it would amount to less than $10 a month added to the veterans' mortgage over the period of the mortgage. There is a slight trade-off because there is no provision for a funding fee if the VA would have to request appropriated funds on the order of $300 million a year to take up the deficit that resulted from the expense factor we have in administering the program. That is a billion-and-a-half dollars over a 5-year period.

It seems to us then that in the reality of the budget environment in which we find ourselves, if we are talking in terms of fighting the deficit, yet at the same time being concerned about the veteran, it may be that this is a reasonable compromise. That billion-and-a-half dollars could go for medical care or some other benefits that would accrue to the veterans as opposed to having it based on the current deficit that we are running.

So, that is the rationale for it. Whether or not there is agreement, and I understand that feelings are quite mixed, we cannot administer the program the way it is without some form of additional funding.

Miss KAPTUR. I think you will get quite a bit of opposition from members of the committee as well as the veterans organizations on that particular issue. We have heard that one before and it is not receiving favorable reception up here, but I appreciate your comments this morning.

I also wanted to ask you about the President's budget that recommends repealing your authority to set the maximum interest rate at which lenders can make guaranteed loans. Today a lender has the ability to offer a veteran a lower interest rate loan yet this is seldom the case. Don't you think that by taking this authority away you will even make the situation worse than it presently is?

General **Turnage**. Please allow me to ask John Vogel to address that.

Mr. **Vogel**. Thank you, Mr. Administrator.

Miss Kaptur, the VA interest rate over the years has always attempted to be sensitive to the market. When we set that rate, if we are a little bit behind the market, with respect to the cost of money, lenders charge points, a point being 1 percent of the loan amount, to make up for the difference in the yield between the VA interest rate and what the conventional market rate would provide. Veterans cannot pay points, so sellers don't want to sell to veterans. Builders don't want to sell to veterans. We believe that the notion of letting the market find a proper rate would be beneficial to the veteran home buyer as well as the veteran home seller.

We have received a little bit of information from FHA on their experience, and I will provide that for the record. By and large, we believe that letting the market set the appropriate rate is consistent with Administration policy.

(Subsequently, the Veterans' Administration furnished the following information:)

The latest FHA information available is for loans made in 1985. During that period some 96 percent of FHA insured loans were at or below the VA rate.

Miss **Kaptur**. We are certainly going to ask to see those FHA numbers for the record. That is in a follow-up question which I won't burden you with. I also wanted to ask a question about your current loan portfolio and proposal that it be sold off over the next 3 years without recourse.

At a briefing at your agency, it was stated that that change in policy would result in an average loss of 30 percent on the face value of these loans. I sit on the Housing Subcommittee of Banking. We ran into the same issue over at FHA. Do you think this is good management, to require that the VA accept a 30-percent loss when all forecasts show the housing market is getting stronger?

Mr. **Vogel**. The notion of selling $300 million per year over a 3-year period, without recourse, is also consistent with Administration policy with respect to letting the market work. We believe that the discount of 30 percent would be consistent with current market conditions. The projection of the Department of Education with respect to selling unsecured student loans is that they would be discounted some 50 percent. Our loans are secured by real property. We think a 30- percent discount or 70-percent yield would be reasonable and would provide an additional measure of revenue to the revolving fund.

Mr. **Edwards**. Your time has expired.

The Chair recognizes the gentlewoman from South Carolina, Mrs. Patterson.

Mrs. **Patterson**. No questions at this time.

Mr. **Edwards**. This winds up the panel from the Veterans' Administration, and we thank the Administrator and his colleagues. We might suggest that some of you hang around because you are going to get an earful on your budget and other matters from representatives of the various veterans' organization. But, thank you very much.

Mr. EDWARDS. The next panel consists of David Gorman, an Assistant National Legislative Director for Medical Affiars, DAV; James N. Magill, Director, National Legislative Service, VFW; R. Jack Powell, Executive Director, Paralyzed Veterans of America; Lt. Col. David J. Passamaneck, National Legislative Director, AMVETS; and Dr. Donald Custis, former Chief Medical Director, VA, and former Surgeon General of the Navy.

All of the witnesses on this panel have appeared before the committee before. They are good friends of ours. We welcome all of you and we're going to ask you to limit your statements to 5 minutes each at the most.

Mr. Gorman, I believe you are first.

STATEMENTS OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS; JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; R. JACK POWELL, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; DAVID J. PASSAMANECK, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; AND DONALD CUSTIS, M.D., FORMER CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION AND FORMER SURGEON GENERAL OF THE NAVY

STATEMENT OF DAVID GORMAN

Mr. GORMAN. Thank you very much, Mr. Chairman. I want to thank you and the committee for inviting us today to present our views on the Administration's fiscal year 1988 budget request for the Veterans' Administration which I am sure you know is a total of $27.6 billion in budget authority, which represents an increase of about $550 million over fiscal year 1987 levels.

The fiscal year 1988 budget request for the Department of Medicine and Surgery calls for overall budget authority in the VA's medical care account of $9.97 billion—an increase of $414 million over the fiscal year 1987 level.

Mr. Chairman, in our view, notwithstanding the proposed funding increase, the VA's ability to provide quality and timely health care to America's veterans will continue to erode.

This is so in view of the fact that $393 million of the proposed increase in the medical care account has been requested specifically to absorb the cost of payroll increases, including the costs of the 1987 civilian pay raise and the 1988 Federal Employees' Retirement System (FERS).

According to the abbreviated budget document we have been provided, the Administration's budget request proposes, among other things: a $75 million rescission to eliminate funding that would otherwise be used during the last 5 months of fiscal year 1987 for the health care needs of so-called "higher income, nonservice-connected disabled veterans" (category C) who are thought to be financially able to provide for their own health care needs (a proposal which is in direct conflict with congressional intent as embodied in Public Law 99-272); treating 13,548 less veterans on an inpatient basis in VA medical centers; treating 113,000 less veterans on an outpatient basis; a projected 1 percent productivity increase (in reality an arbitrary 1 percent budgetary reduction) estimated to save

$58 million and reduce full-time equivalent employees (FTEE) by 1,991 in fiscal year 1988; virtual elimination of the beneficiary travel program; and maintaining and operating 2,600 few hospital and nursing home care beds than mandated by current statute.

However, the cumulative effect of the agency's average medical care employment in fiscal year 1988 will be a reduction of more than 6,200 FTEE (inclusive of the proposed fiscal year 1987 rescission).

According to all estimates, the Administration's proposed DM&S budget for fiscal year 1988 falls at least $300 million short of the minimum funding level necessary simply to maintain veterans' health care services at current fiscal year 1987 levels.

Mr. Chairman, the Administration's fiscal year 1988 medical and prosthetic research request is $198.7 million ($14 million below the fiscal year 1987 funded level).

The DAV has, and continues to be, fully supportive of the VA's combined research efforts. It is discouraging, however, to continue to witness the large disparity in the funding levels for medical research ($185.8 million) and that requested for prosthetic research ($17.6 million). The DAV supports the mission of health services research and development and we are encouraged by and support the funding requested. Likewise, we support the request for $2.4 million to fund an epidemiological study of women Vietnam veterans and the $4 million requested to continue to support the ongoing Agent Orange epidemiological study.

VA's fiscal year 1988 construction request, Mr. Chairman, is lacking any construction funds for new nursing care bed construction. With respect to the Department of Veterans Benefits, we are concerned that the average employment will decrease by some 296 employees in 1988. Since 1980 nearly 5,000 employees have been slashed from DVB and today each regional office is barely staffed at minimum levels to adequately respond to the work load and demands for services placed upon it from veterans and their dependents.

With respect to proposed legislation, Mr. Chairman, the DAV is pleased to support the Administration's proposed cost-of-living increase for service-connected compensation and DIC benefits. As strongly as we support that proposal, we adamantly oppose any effort to index compensation benefits to the annual change in the Consumer Price Index.

Mr. Chairman, the Administration is proposing several legislative changes to the current VA Home Loan Guaranty Program. Of particular concern to most veterans are the proposals that would increase the users fee from 1 percent to 2.5 percent and remove the Administrator's authority to set the interest rates for such home loans.

Mr. Chairman, the DAV is opposed to both of these proposals.

That will conclude my oral testimony.

[The prepared statement of David W. Gorman appears at p. 377.]

Mr. EDWARDS. Thank you very much.

Before we ask any questions, we will have each of the members of the panel to testify.

Mr. James N. Magill, Director of National Legislative Service, Veterans of Foreign Wars. Mr. Magill.

STATEMENT OF JAMES N. MAGILL

Mr. MAGILL. Thank you, Mr. Chairman, for the privilege of appearing before this distinguished committee to present the views of the Veterans of Foreign Wars of the United States with respect to the fiscal year 1988 budget for the Veterans' Administration as proposed by the President.

As you know, the President has proposed a fiscal year 1988 funding level for the Veterans' Administration of $27.6 billion. This figure represents a $550 million increase over last year's total. However, the President is also proposing a $75 million rescission of fiscal year 1987 funds which the Congress has already agreed to spend on VA programs. Our first recommendation, Mr. Chairman, would be for the Congress, when presented with the rescission message, to reject it.

Most of the $75 million would come from the Department of Medicine and Surgery. In submitting the Administration's proposal, it was suggested the impact would be more greatly felt by category C patients as defined by Public Law 99-272. However, the VFW cannot visualize how these particular patients could be the only ones targeted. We predict that all categories will be affected and this certainly includes category A patients who now enjoy, thanks to the Congress, VA health care as an entitlement.

Mr. Chairman, the President's budget proposal would scale back VA medical care by reducing VA employee levels by 3,810. Of course, this reduction in staff will only lead to a lesser number of patients being treated. This budget recommendation will effectively reduce admissions for inpatient, nursing home and domiciliary care by almost 12,000. There will also be a 113,000 reduction in outpatient visits. These decreases cause the VFW much concern inasmuch as we predict an increase in demand for VA health care rather than a decrease.

The VFW is also concerned over the VA's $68 million funding level for the beneficiary travel account. We do not believe this amount will even come close to meeting the needs of our veterans. We have estimated this figure will barely provide for "emergency" transportation needs and, therefore, should be substantially increased.

With respect to major construction projects, the President is requesting $525.7 million, an increase of $36.9 million over fiscal year 1987. While the overall budget does show an increase, we are disappointed that the "replacement and modernization" activity shows a $102 million reduction from the fiscal year 1987 level. Approximately 53 percent of all VA beds are housed in buildings which are 30 or more years old. It can readily be seen that, unless the "replacement and modernization" activity is substantially enhanced, the VA's primary mission will be in jeopardy.

Mr. Chairman, several legislative initiatives have been proposed by the President in his budget recommendations. One such proposal would standardize the cemetery plot allowance to that of the burial allowance. Of course, this innocent sounding term "standardize" means nothing more than another reduction in benefits. The VFW not only opposes reducing plot allowance eligibility solely to those in receipt of disability compensation or pension, but has adopted a resolution which calls for an increase in the allowance along with expanding the eligibility requirements. It should be kept in mind that the plot allowance is the single monetary benefit available to all veterans who served their country during wartime. It should also be noted that the plot allowance constitutes a significant portion of the operating budget for the various State veterans' cemeteries.

Mr. Chairman, the President's fiscal year 1988 budget is recommending two legislative proposals which would, in our opinion, severely undermine the very successful VA Home Loan Guaranty Program. One such proposal would increase the user fee for a VA guaranteed home loan from 1 percent to 2.5 percent. Inasmuch as we opposed the establishment of a user fee and its subsequent increase from one-half of 1 percent to a full 1 percent, we are now even more committed in our opposition to this proposed excessive and unwarranted increase.

Mr. Chairman, the administration is also proposing to repeal the Veterans' Administration's authority to establish a home loan interest rate. We believe departing from this policy would be a serious mistake and detrimental to the veteran's best interest.

Mr. Chairman, this concludes my oral presentation. Thank you very much.

[The prepared statement of James N. Magill appears at p. 385.]

Mr. **Edwards.** Thank you very much.

Mr. R. Jack Powell, Executive Director, Paralyzed Veterans of America. Welcome, Mr. Powell.

STATEMENT OF R. JACK POWELL

Mr. **Powell.** Thank you, sir. It is always a pleasure to be here in so much more of an intimate setting than a few minutes ago.

Firstly, I would like to ask that my statement as submitted——

Mr. **Edwards.** Without objection, it will be included in the record.

Mr. **Powell.** I would also like to ask that a copy of the report, executive summary of a report called Veterans Health Care Actions and Interactions, which has been provided to the members of the committee and to the staff, be made part of the record.

Mr. **Edwards.** Without objection, so ordered.

[The report Veterans Health Care Actions and Interactions appears at p. 393.]

Mr. **Powell.** Thank you, sir.

This report, Health Care Actions and Interactions, evolved about 2 years ago as an effort to look at the various choices that people might have to make when it comes down to the veterans budget to see what the ramifications of those were.

It was very helpful having done that as we got ready to look at the 1988 budget because not only are we talking about veterans as a special and distinct group of people, we are talking about them as part of the larger framework of society in America.

What we found is that any action taken to veterans or veterans' health care has a ramification and has an outcome. We look specifically, though, for the first time at four individual districts of the VA, at a grass roots level, to see what happens to individual veteran, not to a nationwide survey, but what happens to individual veterans. What we found is that the options that have been so frequently proposed have different but distinct effects as we look at different areas of the country.

When we looked in upper New York State at that medical district, we saw that the fighting there was between young and old. When we looked in the State of Florida, it was between male veterans and elderly females, who presently occupy the nursing homes, and veterans we want to get into them. When we looked at the Arizona district, we found we were talking about a largely rural health care setting and problems that go along with that. We looked at Chicago as kind of endemic or typical over the Rust Belt area. We found there the veterans we were talking about, some 75 to 85 percent, were black single males, two-thirds in the poverty level of income. We were talking about racial impact besides poverty impact.

So these decisions that we are going to make and that you all are going to make are indeed important. It is interesting that the VA budget in 1976 was 5 percent of Federal outlays. In 1986 it was 2.8 percent; and if this budget which has been presented is passed, VA funds will amount to about 2.4 percent of all Federal outlays. If we were talking at the same percentage today that the VA budget was in 1976, we would be arguing over $50 billion. Today we are arguing over about 27.6.

Notwithstanding the fact that some have called this budget the best budget in the VA history, I frankly doubt that that is correct. I am very proud that a majority of our health care testimony today will be part of and be made by Dr. Donald Custis, former Chief Medical Director of the VA, but also it comes out as a result of unprecedented action of four of the major veteran service organizations joining together to attempt to lay out the amount of money that in their estimation it would take to live up to the commitments that the people of this country and the Congress of this country have promised to its veterans.

Certainly a lot of issues have been talked about, such as the $75 million rescission which is, frankly, ridiculous on its face and shouldn't be talked about much more. I am more interested in other things. The Administrator made a reference today to staffing and many questions about nursing shortages. Four months ago, and this committee has a copy of it here, I asked the Administrator how many they had on board and how many they were short in categories of nurses, physical therapists, respiratory therapists, pharmacists and occupational therapists.

I have not yet gotten an answer except to receive an answer from the Veterans' Administration to say that they were going to do a study to find out. In the interim, somebody agreed to a budget that cut about 6,000. I don't know how anybody can agree to cut something from something before they knew how big they wanted to end up being unless, of course, the only goal is to just make it smaller in the long run. Maybe that is the point.

We know that there are about 22,000 veterans every month who are turned away from VA outpatient care. In the last session of Congress this committee attempted to address that problem. It didn't stand up in the conference committee. We hope you will address this problem again.

With that, sir, and with our testimony as part of the record, I would be glad to conclude my statement and take any questions.

[The prepared statement of R. Jack Powell appears at p. 388.]

Mr. EDWARDS. Thank you.

The next member of the panel is Lieutenant Colonel David J. Passamaneck, Nationala Legislative Director, AMVETS.

STATEMENT OF DAVID J. PASSAMANECK

Colonel PASSAMANECK. Thank you, Mr. Chairman. I would, of course, request my printed statement as submitted be included in the record at this point.

Mr. EDWARDS. Without objection.

Colonel PASSAMANECK. At this point I will highlight some points in that statement and generally summarize.

AMVETS is pleased to present our views on the aministration's proposed budget for the Veterans' Administration for fiscal year 1988.

The general attitude of the administration toward the Americans whose military service has earned the entitlements and benefits which a grateful Nation has provided, is to treat that group, our veterans and their families, as if they have no greater claim on budgetary resources than a myriad of Government funded programs which, at least rhetorically, are to be subjected to stringent economizing in the name of deficit reduction. The Government programs which comprise the greatest portion of ever expanding, largely out of control spending, are those programs which respond to the demands of politically powerful special interest groups who, in most cases, have no legitimate claim on the Federal treasury, and a far less justified claim than veterans.

The Veterans' Administration budget for fiscal year 1988 calls for $27.6 billion to fund medical, compensation and other programs for 27.6 million veterans, eligible members of their families, and survivors of deceased veterans. Although the request is nearly $550 million greater than the current fiscal year 1987 estimated requirements this represents little more than keeping pace with the increasing cost of current services.

VA's $10.7 billion request for compensation payments is based on estimates that 2.2 million veterans with service-connected disabilities will remain eligible for monthly payments, along with 323,000 survivors of veterans who died of service-connected causes. The request provides for a 3.5 percent increase in compensation rates and additional legislation will be proposed indexing the annual compensation cost-of-living adjustment to changes in the Consumer Price Index. AMVETS, as it has in the past, remains opposed to the automatic indexing of compensation and DIC rates to the Consumer Price Index. The special needs of veterans based on their age classification and their proportionately intense requirement for health care would not be equitably reflected in the general Consumer Price Index. Indexing compensation would also de-emphasize the current thorough evaluation of the compensation system which usually accompanies the legislative process of periodic adjustment, not only of rates, but of collateral compensatory factors such as presumptions and special entitlements.

We have no quarrel with a proposed reduction in readjustment benefits of about $136 million attributable to an anticipated lower number of eligible veterans. We do, however, strongly oppose a proposed increase in the VA home loan funding fee from one to 2.5 percent effective 1 June 1987. Anyone with experience in the ways of Government will readily understand that this 150-percent increase, if enacted, will only be the first step in the eventual destruction of the loan guaranty program as one of the most universally beneficial and popular veterans' entitlements, and that a 1.5 percent increase to the origination fee will add $3,000 to the cost of the average $70,000, 30-year VA fixed mortgage, will not be applied to current VA programs, but revert to the Treasury, and will drive the younger, first-time veteran buyer from the housing market.

The proposals for operation of the VA Department of Medicine and Surgery lead off with a shocking request for a $75 million rescission to eliminate funding that would otherwise be used during the last 5 months of fiscal year 1987 for the health care of higher income, nonservice-connected disabled veterans (category C) who are considered financially able to provide for their own health care. Although this rescission of funds already appropriated is designed to affect only the category C, or lowest priority of veterans eligible for VA health care, the practical necessities of the medical care delivery system will result in this sharp reduction of resources adversely affecting both service-connected and indigent veterans as well.

AMVETS has been proud to join with the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States in formulating a detailed, independent budget proposal for the VA Department of Medicine and Surgery, copies of which have been widely distributed to include the member and staff of this committee. This proposal calls for the authorization of approximately $1.2 billion more than the administration request and reflects what we believe to be the minimum acceptable level of medical service to veterans. Over $800 million of this increment represents uncontrollable expenditures and less than $400 million would be committed to initiative programs. We respectfully invite your consideration of this alternative, independent budget for DM&S.

[The prepared statement of David J. Passamaneck appears at p. 408.]

Mr. EDWARDS. Thank you very much, Colonel Passamaneck.

And now we are going to hear from the last member of the panel, Dr. Donald Custis, former Chief Medical Director of the VA and former Surgeon General of the Navy.

Dr. Custis.

STATEMENT OF DONALD CUSTIS, M.D.

Dr. CUSTIS. Thank you, Mr. Chairman.

Mr. EDWARDS. Without objection, your full statement will be made part of the record.

Dr. CUSTIS. Thank you.

It has been my pleasure to serve as consultant in the development of this independent budget and now to present to you an abbreviated overview of the document.

The overriding concern of all veterans today is the preservation of their access to the health care to which they are entitled.

The four major veterans service organizations in this, their first effort at constructing a VA budget proposal, have therefore limited their attention to the health service budget aspect, focusing on the veterans' human needs rather than so exclusively on dollars. This unprecedented action is predicated on several concerns of such magnitude that reactive response to OMB budget decisions was felt to be no longer sufficient. Those concerns, in fact, become the major issues influencing the shape and character of this budget document.

Listed on this placard are a few examples of such issues: Changes in the demographic characteristics and health care needs of the veteran population, dubious OMB budget formulation practices, health care systems interactions, and the ever-continuing advances in expensive medical technology.

We are all familiar with the Nation's aging veteran phenomenon. Ten years from now almost 40 percent of all veterans will be over the age of 65 and they will constitute two-thirds of all living males of that age.

There is an alarming lag in the revamping of VA medical facilities and programs to meet changing and growing needs.

The entitlement veteran category under Public Law 99-272 will require more, not fewer, resources and the more convincing commitment than has thus far been made apparent.

We challenge the arbitrary budget practices used by OMB which have annually resulted in unwarranted erosion in patient care capability. Forced absorption of uncontrollable annual cost increases, disallowance for full inflation, arbitrary fiscal penalty for predicted productivity increase, incomplete funding for new facility activations, and the imposition of unreal work load projections all fall under this category of favorite OMB detrimental gimmicks.

The VA is in every sense an integral part of the Nation's pluralistic health care system. The VA purchases much of its medical services from the private sector. There is close interaction with academia. Reductions in Medicare/Medicaid funding and growth in demand for private uncompensated care has an impact on the VA's system from those medically indigent veterans who have lost the access to private care.

It is particularly ironic that, with the rapid advance of costly medical technology, the VA unfunded equipment account, in which the backlog considerably exceeds a half billion dollars, remains a favorite target for reprogramming money to meet other cost absorptions. Obsolete equipment seldom provides for quality medical care.

In the construction of the budget, a number of uncontrollable items are encountered. Listed here are such items, the cost of which must be accommodated and added to the previous year's final appropriation just to maintain current services for the coming year. Unless, of course, they are to be absorbed.

Based on recent planning documents by the VA and the Congressional Budget Office, which addressed the impact of the aging veteran, we have selected targets for the year 1990 which we felt to be most reasonable and constructive. This budget attempts to move toward those targets, supported through the next three annual budgets. The proposed fiscal year 1988 goals are shown in the middle column.

One can see here how the VA medical budget builds from the 1987 appropriation to the fiscal year 1988 request. Costs to just keep services current in fiscal year 1988 require substantial increases.

Incidentally, requested fiscal year 1987 supplemental funds in the President's budget are one-half off what is necessary. The remainder is to be absorbed.

The President's fiscal year 1988 budget for DM&S falls short by some $450 million of providing for current services and calls for a personnel cut of at least 6,000 FTEs.

Note that of the $1.2 billion on that last placard, representing a change from 1987, only $368 million is for new initiatives, which initiatives are listed on the next two placards.

Funds shown here will provide for an additional 21,500 inpatients treated and 400,000 outpatient visits.

We propose re-establishing and financing a separate account to provide continuing education to some 100,000 employees and increasing the funds to augment the physician house staff and specialties critical to the VA.

We support the multi-year clinical computer acquisition program. The President's budget, incidentally, reduces that funding by $38 million from DM&S current estimates.

The $90 million for patient travel replaces monies lost in the fiscal year 1987 budget. The President's budget proposes to cut by 50 percent what was spent for patient travel in 1985. We recommend "fencing" the travel portion of that travel fund.

The net cost of all extended care programs is $108 million and represents the major focus of all of our initiatives. The following additions are provided for: 635 VA nursing home beds through both construction and conversion; 2,981 community nursing home beds; 8 hospital-based home care teams; 22 additional adult day health care centers; 15 community residential programs; 20 additional geriatric evaluation units; three additional GRECCS; 40 respite care; and 20 hospice care programs.

The President's budget includes only one of these extended care initiatives and that is at a very reduced level; namely, a modest increase in community nursing home census.

This next placard provides the same presentation for the medical research budget. Initiatives programmed here are very modest: An additional $4.6 million for biomedical research; $3 million for rehabilitation engineering research; and an additional $2 million for health services research and development. The largest increases in this account are, again, the uncontrollables.

There are only three initiatives in the medical administration account: Funds to cover a recommended management consultant study for the Department of Medicine and Surgery central office especially to determine a proper staffing level and organization; $6 million to reactivate the VA health professional scholarship program for nurses and other scarce specialty technicians; and funding for the development of the congressionally mandated quality assurance model.

The next placard represents the bottom line for all DM&S accounts. We are recommending an increase of $17.6 million for State veteran home grants to accommodate those projects already processed and ready for funding.

I would like to reiterate that the major portion of the cost increases is in uncontrollable items in the amount of $860 million. This year's veterans service organizations' proposed budget does not address the VA's construction program. However, we are constrained to recommend continuation of VA nursing home construction for fiscal year 1988, this in contrast to the President's budget which provides no additional nursing home construction. Projected 1990 shortfalls can only be obviated by the immediate construction of nothing less than 12 120-bed facilities. This problem is discussed in depth on pages 29, 30 and 49 of the budget document.

I thank you, Mr. Chairman.

[The prepared statement of Dr. Donald Custis appears at p. 418.]

Mr. **Edwards**. Thank you very much, Dr. Custis. I know that the chairman and the ranking Republican, Mr. Solomon, join me in congratulating you and certainly the volunteer organization for putting together this budget. It is really a splendid job. It is going to be of great help to us, I am certain.

Mr. Solomon.

Mr. **Solomon**. Mr. Chairman, I understand there might be a vote coming up here shortly, but let me just concur with the words of Don Edwards. I think that your presentation is outstanding. It is certainly unprecedented. Your budget is based on human need of the veteran, and that in itself is extremely helpful to us.

The Administrator, the Administration, of course, are bound by recommendations by the OMB, they are also bound by restrictions put on by this Congress with prior legislation in prior years. I think maybe the final answer lies somewhere in between. Certainly after we have had a chance to really look into your presentation today and we certainly want to do that and then get back to you, in particular, Dr. Custis, but also all of you other gentlemen, to develop and explore the intricacies of it.

I am extremely concerned myself with the patients' travel allowances, how you deal with that, particularly for rural areas like my district. I don't represent 33,000 square miles like Charley Stenholm. I only represent about 11,000 square miles, but it is a major concern to me, too.

Again, I am not going to take up the rest of the time of the committee. We will have a lot more questions to ask you in writing.

We deeply appreciate your coming and giving us this kind of budget to look at.

Mr. **Edwards**. Are there questions from any member of this committee?

Mr. **Applegate**. Thank you, Mr. Chairman. I would really add to the accolades that have been heaped upon the gentlemen before us, and your organizations, for really something that I guess is somewhat unprecedented, but something that is necessary. I believe that as Mr. Solomon has said, his words were very accurate, I don't see how because we are dealing in human needs, and we are dealing with a very special group of people and I can't see that we are going to do anything in coming close to balancing the budget—unfortunately, that is the excuse that is usually rendered.

If I had a prediction to make, I would say that what we will finally come through with is going to be something that will be resembling what you have presented rather than what the Administration has presented.

I certainly will look forward to working with your organizations, doing everything I can in my power to help, and I thank you for coming before the committee.

Mr. EDWARDS. Miss Kaptur.

Miss KAPTUR. Thank you very much.

I just wanted to mention to the chairman, as well as to Dr. Custis, good to see you again, that one of the confusing parts about this testimony for me has been the bottom line of the budget proposed by Dr. Custis as well as the budget proposed by the Administration and so forth, because you are dealing with appropriated levels and I am aware that the staff is going to try to work all of this out, but I am not sure what the differences are in my own mind and I hope that is made clear to us on the committee.

I want to specifically request that because it is a little confusing to look at the difference between what you are asking for, what current service levels are. But I wanted to ask Dr. Custis, you mentioned nursing homes in your testimony and have to say in my district what my veterans talk to me about all the time, and in your opinion, as former VA Chief Medical Director and former Surgeon General, are there sufficient community nursing homes or potential for such homes to meet VA's new policy and reliance On the private sector, the contracting out as specific they have been talking to us about your proposing that the VA duly move into this arena more strongly.

Could you comment a little more on that?

Dr. CUSTIS. Miss Kaptur, I think those who are familiar with the health care scene today would give that a catagorical "no" as an answer. There simply are not. I think as long as 3 years ago the American Medical Association came out with a study in which they made the statement that if the country were to build a 100 bed nursing home every day from that time until the year 2,000, they would not keep up with the demand through the 1990's.

On top of that, we see still something on the order of 20 States that have moratoria on nursing home construction in an effort to hold down their Medicaid costs.

The aging veteran, that phenomena, is occurring about a decade ahead of the graying of America.

I think in general, the public has yet to realize the seriousness of what the impact of the graying of America is going to be. We think that it is unreal of the Veterans' Administration to depend so heavily on community bed availability through the 1990's. To do so would put the veteran in competition with the civilian who has every bit as much need and may well result in escalation of costs simply due to such competition.

Miss **Kaptur**. Thank you. I had one question you can answer very briefly.

In your testimony you talk about unmet needs in the medical area where there are shortages on the medical side or technical side. Could you tick off what those might be because I have tried to develop legislation to promote additional education or perhaps some kind of in-kind service for physicians or nurses get an education through the VA and then have to give time back through the VA or some other form of Federal service.

I have constantly been told by some that there are plenty of doctors, maybe there is a little nursing shortage.

What kind of help do you indicate is missing?

Dr. **Custis**. It is true that the country has an adequate supply of physicians and there are those who predict there will be an oversupply of physicians. But the need of the Veterans' Administration and military medicine are something else again.

There are certain specialities in which they have a great deal of difficulty in recruiting and retraining, notably, are the orthopedic surgeons, neurosurgeons, general surgeons, radiologists.

I think those are examples where the shortage has been chronic in both VA and military medicine and the reason is that they can't compete in terms of income.

Miss **Kaptur**. Thank you.

Mr. **Edwards**. Mr. Bilirakis.

Mr. **Bilirakis**. Thank you, Mr. Chairman.

Thank you, Madame.

I think it is important to note that until just probably the last 2 or 3 minutes, the Veterans' Administration representatives that Mr. Edwards invited to stay did stay. General Turnage was here and Dr. Gronvall was here, Dr. Brown was here, and a number of others, and many are still in the audience, and I think that speaks well for their interest in the testimony.

Miss Kaptur made a point that I wanted to make here. It is so important to compare. We compare patient visits and what not, you know. That is significant when it comes to the dollars, it is important to be able to compare apples to apples and it is not easy to do so.

I would ask that the staff help us out in that regard when we go into our specific hearing, Gerry, and in our subcommittee so that we can compare apples again with apples.

I have for quite some time made a point, certainly in my district and even here, that the veterans' organizations—and Jack has certainly talked about his veteran organization—have not understood enough the term of jointly presenting their proposals and so I am just tickled pink and I think I speak on behalf of all my colleagues that you have gathered together to present this proposal.

We need something like that because it is not, and should never be, a case of let's tear apart the administration's ideas. You have given your ideas and you have given them to us clearly, and I commend you for it.

I do note that the American Legion is not included as one of the parties. Is there any explanation for that, Dr. Custis, or Mr. Powell, or whomever?

Dr. **Custis**. I would defer to Mr. Powell.

Mr. **Powell**. The American Legion was invited to participate and chose not to. Their reasons will have to be their own.

Mr. **Bilirakis**. Thank you. I have nothing further.

Mr. **Edwards**. Are there any other questions?

If not, again, we all thank you very much for this tremendous enterprise. It is going to be of great help to us and we appreciate it very much, and with that we adjourn.

[Whereupon, at 12:05 p.m. the committee adjourned subject to the call of the Chair.]

PROPOSED VETERANS' ADMINISTRATION BUDGET FOR FISCAL YEAR 1988

WEDNESDAY, FEBRUARY 4, 1987

House of Representatives,
Committee on Veterans' Affairs,
Washington, D.C.

The committee meeting was called pursuant to notice, at 9:02 a.m., in room 334, Cannon House Office Building, the Honorable G.V. "Sonny" Montgomery (chairman of the committee) presiding.

Present: Representatives Montgomery, Applegate, Mica, Evans, Kaptur, Penny, Staggers, Rowland of Georgia, Gray, Robinson, Harris, Kennedy, Patterson, Johnson, Jontz, Solomon, McEwen, Smith of New Jersey, Ridge, Rowland of Connecticut, Dornan, and Davis.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

The Chairman. The committee will be in order. Today we are continuing hearings on the Veterans' Administration budget. Yesterday, we heard from the Administrator of Veterans Affairs and several veterans' organizations who presented an unified health budget which will be a great help to this committee.

This morning we will hear from several VA managers from various hospitals throughout the country. The purpose of receiving testimony from these individuals is to get their reaction to the proposed budget requests and the impact the proposed budget would have on their ability to provide quality care to all eligible veterans.

In addition, we will hear from representatives of the American Legion and the Vietnam Veterans of America.

We are pleased to have Mr. Wayne Hawkins, Director of the VA Medical Center in Dallas. Mr. Hawkins, please come to the witness stand. Dr. Ralph Goldsmith, chief of staff of the VA Medical Center in San Francisco, and the president of the VA Chiefs of Staff Association, Dr. Howard H. Green, chief of staff of the VA Medical Center in White River Junction, VT. Will those gentlemen please come to the witness stand, and Dr. Green is

We are especially pleased to have on the panel Ms. Jamesetta A. Halley, chief nurse of the VA Medical Center in East Orange, NJ.

We welcome all of our witnesses. We do not really need any statements this morning, we just want to get your personal feelings about this budget and any suggestions you might have to this committee. We are all on the same side here. We are just trying to help the veterans the best we can. I know you wouldn't be working in the system if you didn't believe that. Also, if you could tell us about the rescinding of the $75 million of funds that has been requested by this administration, how that would affect your operation.

The Chair would like to recognize the ranking minority member, Jerry Solomon, of New York.

OPENING STATEMENT OF HON. GERALD B.H. SOLOMON

Mr. SOLOMON. Thank you, Mr. Chairman. Mr. Chairman, as we begin day two of these budget hearings, I want to commend my colleagues on both sides of the aisle for their devotion not only to the fiscal responsibilities that we have to have but also the very real human needs for our Nation's veterans. This concern was also evident in General Turnage's thorough and forthright presentation of the VA budget proposal yesterday.

I think it is safe to say that no matter how we may differ on selected portions of the budget, we all appreciate his devotion and his dedication and commitment to his job.

I would also like to express the appreciation of the committee for the testimony presented by Dr. Custis and the representatives of the four service organizations who appeared yesterday. Mr. Chairman, no budget deliberations would be complete or effective without the input of those men and women who actually work in the field providing the services and the caring for the elderly and the sick among our Nation's veterans. With that in mind, it gives me great pleasure along with you, Mr. Chairman, to welcome those representatives from the medical nursing and administrative communities, from our VA Hospital system, who are working to make quality medical care a reality for millions of veterans.

Last but not least, I welcome the representatives of the American Legion. I have been a member of that organization for some 30 years. I also welcome the Vietnam Veterans of America, in grateful appreciation not only for their appearance today but for their ongoing work on behalf of the Nation's veterans.

Mr. Chairman, we look forward to their contribution here today, too. Thank you.

The CHAIRMAN. Thank you. The Chair recognizes Mr. Ridge.

OPENING STATEMENT OF HON. THOMAS J. RIDGE

Mr. RIDGE. I thank the gentleman for yielding. Mr. Chairman, regrettably, I was unable to attend yesterday's hearing. I do understand that my colleagues on both sides of the aisle did their usual excellent job in responding to the concerns on behalf of veterans but particularly in responding to the administration's budget proposals. Although today's hearing is intended to focus on the health care budget, if I may, I would like to make one or two brief comments in response to the administration's proposal to raise the home loan origination fee from 1 to 2.5 percent. Frankly, Mr. Chairman, I am surprised and dismayed that the administration has ignored the strong and unanimous opposition in the past from Congress and the veterans' community to any increase in the home loan fee and I am grateful for the support of my chairman and the vice chairman on the resolution that I have introduced. Thirty-five of our colleagues have joined with us in rejecting that proposal.

Secondly, Mr. Chairman, I wanted to make a few observations with regard to the proposed $75 million rescission. Under the guise of deficit reduction, this proposal attempts to eliminate funding that would otherwise be used for the care of higher income nonservice-connected veterans. In the last Congress, we enacted landmark legislation implementing a means test, for the veteran seeking health care. As you know, Mr. Chairman, I have made no secret of my opposition to the means test but I also respect and understand why the majority of my colleagues supported it in light of the few alternatives to budget cutting requirements imposed on this committee.

This rescission, however, goes well beyond the congressional intent of legislation implementing the means test. Again, I just wanted to publicly thank my chairman and my vice chairman for co-sponsoring with me the resolution expressing Congress' disapproval of the $75 million rescission and ask unanimous consent that the totality of my comments be included as part of the record.

The CHAIRMAN. Without objection, so ordered.

[The prepared statement of Mr. Ridge appears at p. 453.]

The CHAIRMAN. I was pleased the gentleman from Pennsylvania would take this lead in introducing this sense of the Congress resolution which a number of Members, including Mr. Solomon and myself, have signed.

As to the home loan program, many of us have re-financed our GI loans and this money has gone directly into the Treasury. The 1 percent is working well. There is no reason to add another 2 or 2.5 percent to the home loan program. In fact, that takes away any advantage that the veteran might have on getting home loans. There are witnesses here this morning that will talk about the $75 million recession and how it would affect their particular operations.

I thank the gentleman for taking this lead. It has been helpful to us.

Dr. Goldsmith, we have your name down here first. We will start with you and then Mr. Hawkins, Dr. Green, and Ms. Halley.

What effect, if the Congress does rescind the $75 million appropriated for health care for this fiscal year, how would that affect your operation, your personal views on that? I hate to ask you, but if you could be brief, it does help the committee.

STATEMENTS OF DR. RALPH GOLDSMITH, CHIEF OF STAFF, VA MEDICAL CENTER, SAN FRANCISCO, CALIFORNIA AND PRESIDENT, VA CHIEFS OF STAFF ASSOCIATION; C. WAYNE HAWKINS, DIRECTOR, VA MEDICAL CENTER, DALLAS, TEXAS; DR. HOWARD H. GREEN, CHIEF OF STAFF, VA MEDICAL CENTER, WHITE RIVER JUNCTION, VERMONT; AND JAMESETTA A. HALLEY, CHIEF NURSE, VA MEDICAL CENTER, EAST ORANGE, NEW JERSEY.

STATEMENT OF DR. RALPH GOLDSMITH

Dr. GOLDSMITH. Yes, sir. Thank you. I appreciate the opportunity to respond, although I will speak principally for myself, I would like to point out that much of what I and Dr. Green will have to say this morning will actually be representative of comments that have been made to us by many of the chiefs of staff throughout the system, although we don't speak for them in any official capacity. I think it is important for everyone to recognize that we will be representing their views as well.

In terms of the specific response to the question of the $75 million rescission, I think it is fair to say that it would be a disaster for my own institution. San Francisco VA Medical Center is already at significant risk for not being able to finish out the year with the budget that we already have. As a matter of fact, it is very clear because of the extraordinary costs of taking care of patients with AIDS, that in fact at the current rate of expenditure, we will run out of money about the first week in August.

Any further reduction to the budget that we have available to us for this year would simply decrease the length of time that we will be able to continue to operate.

The CHAIRMAN. Thank you very much. I appreciate your mentioning about the AIDS problem. Mr. Hawkins?

STATEMENT OF C. WAYNE HAWKINS

Mr. HAWKINS. Thank you, Mr. Chairman. I appreciate also the opportunity to share my views with the committee. I might just address, if I could, the fact that we have already this year started the fiscal year 1987 budget in my institution with some $4 million in cuts.

The CHAIRMAN. Each one might tell what their positions are. I have read it but I would like for my colleagues to know what your job is.

Mr. HAWKINS. Okay, sir. I'm the medical center director at the VA Medical Center in Dallas, Tex.

We started this fiscal year with an original cut of $2.6 million that was based on the resource allocation model, the workload reductions, and the 1 percent productivity reduction. In addition, we sustained another $1 million cut with absorption of the pay raise and also the health benefits increase for employees.

To meet these adjustments, we had to reduce all of our operating control points in all departments including drugs, supplies and so forth by 10 percent across-the-board, and we had to cut 28 employees from our rolls in order to sustain the present cuts.

To add another cut on top of us at this point would be disastrous for my institution. We have clinics right now that have backlogs in some cases up to 6 months before we can get patients in.

Mr. Chairman, for the last 2 or 3 years, we have had this 1 percent productivity cut given to us. It has gotten to the point that we just cannot any longer sustain these kinds of reductions if we are to maintain the quantity and the quality.

In Dallas, our workload is increasing. Last year, we had over 50,000 additional outpatient visits as compared to the year before. We are seeing a lot of new patients, new veterans that have not used the VA system before. This year, our admissions are 1,000 above this time last year.

In summary, Mr. Chairman, we are at the breaking point in terms of trying to meet the workload with existing funds and any additional cuts would be disastrous.

The CHAIRMAN. So I will have it clear in my mind as well as other members of the committee, as I understand it, OMB tells the health care systems of the VA to make a 1-percent reduction and call it management efficiency. Is that what it is called?

Mr. HAWKINS. Yes, sir.

The CHAIRMAN. You have to cut back 1 percent in your operation. How many people does that affect?

Mr. HAWKINS. In my institution, sir, that amounted to 18 FTE, (full time employees) that I had to reduce this year and this is the third year in a row that we have had to sustain that kind of cut.

The CHAIRMAN. Your workload is increasing?

Mr. HAWKINS. Yes, sir. Our workload, our out-patient workload last year, increased over 50,000 visits. This year, our in-patient workload is 1,000 admissions above last year. The demand is heavy. In the Dallas-Ft. Worth area, we are seeing a lot of new veterans who have not used the system before. We see the workload going up, demand going up, and the budget going down.

The CHAIRMAN. I am a little concerned. I am not sure OMB pays attention to the Congress. They can order 1 percent each year. That is 3 percent. Year after year, it amounts to real money, as they say around here, in jobs. I like the idea of efficiency but you are not adding any personnel, are you, in other sections of your hospital?

Mr. HAWKINS. No, sir. We do well to stay even but we have actually been losing. We have actually in the last 2 years reduced employees.

The CHAIRMAN. We might have to look into this 1 percent each year because it could become a real problem. That is 3 percent. Is it the feeling that this will continue each year?

Mr. HAWKINS. I don't have all the details of the 1988 budget, but it is my understanding that is the plan for fiscal year 1988 also, that there would be a 1 percent-productivity reduction.

The CHAIRMAN. We certainly will look into it. Thank you, sir. Dr. Green?

STATEMENT OF DR. HOWARD H. GREEN

Dr. GREEN. Mr. Chairman, members, I appreciate this opportunity to appear before you. I will be brief in my response since you have gotten a response from Mr. Hawkins.

I am the chief of staff at the VA Medical and Regional Office Center in White River Junction, VT, one of the truly small facilities in the system.

You asked two basic questions: One about the effect of the rescission on my hospital and the second, about the progressive 1 percent cut per year.

We have a paradox in Vermont. We are in the lower quartile of income distribution for this country on a per capita income base, yet the category C veterans walking through the door are 7.9 percent with a system average somewhere around 2 to 3 percent.

The CHAIRMAN. You might talk a little louder. Some of us are old soldiers and we are really having some problems. We will come out to VA and let you check our ears. Talk right into that microphone.

Dr. GREEN. I am headed that way, too, sir.

If the cut is assessed proportionally in my hospital, it would mean over a period of 3 years, the loss of $5.3 million. If you distribute that according to personnel versus all other operating expenses, I would lose $3.1 million or 106 FTE on a base of 587. If you add the 1 percent progressive cut to that, that adds another 18 FTE.

I submit to you that I wouldn't have a hospital left because those cuts would have to come out of the bulk of employment which is professional employment. I am already in the position where I am going to have to cut or recommend to the hospital director that we do not fill 30 of our available beds because of resource limitations and will have to cut out one complete nursing ward or we are going to go under. We are going under any way. This just delays the day.

The 1 percent productivity cut leaves indirect services vulnerable, but that's an illusion. As you are losing FTE, if you are efficient in indirect services, you have no other choice but to take them out of direct services. I submit to you that the Veterans' Administration has some very efficient indirect services.

In addition to those cuts, for the first year we were a so-called RAM loser because the RAM model changed the rules of the game. We lost a net of 7 FTE from that. I have objected to this to Central Office on grounds of a faulty model and have submitted three papers to them to explain the difference and with your leave, I would submit those for the record rather than to go into detail, sir.

The CHAIRMAN. Without objection.

[The information referred to appears at p. 455.]

Dr. GREEN. So that the net effect is that if indeed the scenario is played out, I will be down over 125 full time equivalent employees in 3 years. I cannot run the hospital in its current mission with that kind of loss.

In the budget this year, it looks as though I have increased FTE in the hospital. That is an illusion also, because from fiscal year 1986 budget to the 1987 budget, at least the first iteration, I lost over 30 FTE, 35 to 40 FTE, because of the target allowance. There have been restorations but the restorations are designated restorations and do not make up the deficit of patient care personnel that I will have to lose.

The CHAIRMAN. Thank you very much, Dr. Green. Has this affected your equipment and supplies?

Dr. GREEN. Yes, sir, it has. In order to do a temporary patch on meeting the payroll costs and meeting other costs we are going to have to absorb, like the Federal Employees Retirement System Program, health benefits and a host of other things. Our non-recurring M&R accounts have been essentially frozen. That equals $1.4 million and $129,000 of equipment accounts. Fortunately, we were able to buy some equipment before the freeze came in.

The ability to do the maintenance on the institution to keep it up is frozen until this issue is resolved.

The CHAIRMAN. Thank you. I really don't ever like to hear about the shutting down of wards or beds. It will end up being nothing but an out-patient clinic system. We are going to need those beds in the future and we are not adding any. I would be awful careful about shutting down beds, which you mentioned, 30 beds.

Dr. GREEN. I would agree, Mr. Montgomery, but I believe my charge as the chief of staff is patient safety. If I can't staff adequately, I can't take care of the patients. In my professional mind, my primary obligation is to make sure that we don't hurt patients, and that we take care of them well.

The CHAIRMAN. Thank you. Ms. Halley?

STATEMENT OF JAMESETTA A. HALLEY

Ms. HALLEY. Good morning, Mr. Chairman and members of the committee. I sincerely thank you for allowing me to come before you this morning. I must echo the statements of my physician colleagues——

The CHAIRMAN. You might talk right into that microphone. Just pull it to you, Ms. Halley, and also tell us your position in the VA.

Ms. HALLEY. My position is Chief of the Nursing Service at the East Orange VA Medical Center. I've served at that facility for 2.5 years now approximately.

As I was saying, I think I need to echo the statements of my physician colleagues and also Mr. Hawkins. Mr. Baglio, our medical center director, did share our budget position with me and I am prepared to tell you that we have lost $3.2 million as of fiscal year 1987. We, like our other colleagues, did have a 1-percent reduction and it equated to 19 FTE. Since 1984 we have lost approximately 100 positions.

Although I may not be able to speak for my other colleagues in terms of the support services, I can say that nursing service in the past 3 years has not suffered any reduction in staffing. However, the reductions of the administrative and the support services, have resulted and impacted on us. I think as a hospital, we feel that we are continually able to provide care for our patients but if the reductions in salaries and in monies continue, I don't believe that we will be able to provide the quality of care that we have strove to provide through the State.

I can share with you, what we are finding at East Orange is that we are treating an older age population and we are treating patients with multi-system failures. In any given day, you may find as many as 14 patients on respirators in our acute care areas. Like my colleagues, we have had to close beds. We have closed two units in the past 2 years. It is anticipated if the $75 million is not restored, that we will probably experience additional cuts in FTE and that might equate to additional beds being closed.

So like my colleagues, I would say it would be disastrous for us.

The CHAIRMAN. That is the $75 million, if you got the $75 million distributed out, would you be able to rescind those cuts?

Ms. HALLEY. I think we would probably be able to rescind some of them. However, the damage has already been done, sir, in that over the past years as I shared with you, over the past 2 years, we have already lost 100 FTE. I don't believe that would be restored with the $75 million.

The CHAIRMAN. Do you have a shortage of nurses in your hospital?

Ms. HALLEY. We have experienced I would say a tremendous nursing shortage. I've been with the VA for a total of 18 years and

I've experienced some of the other nursing shortages in the early 1970's and 1980's. I would say this nursing shortage is the worse that we have experienced, not only in the VA, but also my colleagues in New Jersey in the private sector are experiencing the same kinds of demands.

The CHAIRMAN. Thank you very much. The Chair will now recognize members. The Chair will implement the 5-minute rule and will also recognize you according to when you arrived, on either side of the aisle. I think that is a fair way to do it. The Chair recognizes Mr. Solomon, the ranking minority member.

Mr. SOLOMON. Thank you, Mr. Chairman. I was just inquiring as to the size of that East Orange Hospital. I guess it is 870 beds.

Ms. HALLEY. 872 operating beds; that's correct, sir.

Mr. SOLOMON. That's a large hospital.

Ms. HALLEY. Yes; it is.

Mr. SOLOMON. Of those 100 employees, Ms. Halley, that you were talking about, how many of those were nurses?

Ms. HALLEY. Only 10 of them were Registered nurses and that was because we did close a unit, so we did lose the 10 Registered nurses. The others were various members of the hospital and for the most part they were from the support services, MAS, secretarial services, building management services. That indirectly impacts on us because those are the suport service employees, when they are not available, my nurses become generalists. They do the MAS function and they perform the physical therapy in the absence of a respiratory therapist.

Mr. SOLOMON. In listening to all the testimony and talking about the full-time equivalent jobs that have been lost, it seems to me there is a greater loss than the 1 percent per year would represent. There must be other factors involved there. I know that the Congress or the budget has forced you to, in other words, include raises and other items. It must be more than just the 1 percent. I think we have done you dirty further than that.

What other areas have you been forced to include all this in, like the raises? You were forced to put those in; right?

Mr. HAWKINS. I might respond to that, if I could, sir. What we have had to do is to cancel maintenance projects to make up the money for those cuts in employee pay raises and health insurance. We have had to cancel all maintenance projects to maintain a facility that is very old, one building was built in 1939 and the other in 1950. These projects include things like replacing natural gas lines which we are having trouble with. If they go out, the whole hospital is shut down. Elevator compliance and Asbestos removal, which are safety problems, both with the patients and employees. We have had to cancel all of those projects to put that money into the patient care arena.

Also, we have had to take equipment money which is non-recurring money, to use for recurring purposes. This is disastrous in my opinion to take equipment money to pay for those kinds of things because if we can't maintain the state-of-the-art equipment and replace equipment that is either by technology or by longevity worn out, we cannot provide quality care. We have been through these trenches before on equipment. It is disastrous in a facility—we have 820 beds. We have to maintain that equipment. It is disastrous to try to fool with those funds and not be able to buy or maintain our facility and equipment.

Mr. SOLOMON. Do you want to respond to that, Dr. Green?

Dr. GREEN. Yes, Mr. Solomon. I think you have to recognize also that besides reductions in absolute dollars or buying power of dollars, we are absorbing system mandated programs that are not backed by FTE. This causes a re-distribution of our workforce. For example, the ADP initiative was not accompanied by people. In order to run an ADP operation, the de-centralized hospital computer program, it had to come out of existing personnel.

The place where it inevitably comes from is from direct patient care personnel. I think it is a mistake to think that you can keep cutting your indirect costs, your support people and functions. The largest number of personnel in the hospital are direct patient care people.

In addition, the quality assurance and utilization review initiatives have come without the designation of man power, as have the data validation process and the A-76 initiatives. You are looking at significant re-distribution because of system mandate from direct patient care people to non-direct patient care people.

The other thing is activations, activations of the system are coming off the top so that they are coming out of the existing hospital system. There is more than meets the eye in just dollars in the budget. There is a re-distribution of hospital personnel going on and I think Mr. Hawkins and Dr. Goldsmith can speak to that.

Mr. SOLOMON. If I could just get on to one other question and maybe some of you can respond, some of the other people. I think maybe Mr. Hawkins you might be able to answer this better.

How would you handle category C veterans if there is no funding for the remainder of the fiscal year 1987 budget due to the $75 million rescission? What would happen to those class C veterans? Not what you would want to do, but what would you be forced to do?

Mr. HAWKINS. I think we would be forced, sir, to really stop those veterans at the eligibility desk and turn them away. We presently are having extreme difficulty as it is now trying to meet those needs without the cuts. I think once they get into the system, our doctors and our staff are going to feel they have the moral obligation to provide that care and the only choice I see would be to stop them at the door and turn those veterans away.

Mr. SOLOMON. I was afraid of that.

The CHAIRMAN. While we are on that, would you mind commenting on that, Dr. Goldsmith, since you are chief of staff?

Dr. GOLDSMITH. Yes, sir. I would be delighted to. I think one of the problems that we have in dealing with the category C veterans is that it presumes, since we can only take care of them if we have adequate resources, that we see all of the service-connected and the category A and category B patients first and then we can take a look to see what else is left in order to take care of the category C patients. Of course, nothing could be further from the truth. The reality is that they come in in a random fashion and for the doctor on the front lines or for the clerks at the admitting desks, there is no way for them to know at any moment in time what resources may be available later in the year or later in that day, for that matter. So that in reality, a decision has to be made up front as to whether the patients who would fall into category C can be taken care of.

The CHAIRMAN. I would point out to the members of the committee, category C, they might not be lower income, or they might be service-connected, or on pensions, but some of these people are Congressional Medal of Honor winners. They have the Silver Star and have had great combat records but they happen not to come under the category A. We really want to be careful. We don't really want to knock out these category C's because they have given us some great service to our country. I think you need category C in effect to survive the system any way. We hope that the administrators and chiefs of staff would consider that.

Dr. GOLDSMITH. Yes, sir. We feel very strongly about that as well.

The CHAIRMAN. Mr. Harris of Alabama.

Mr. HARRIS. Thank you, Mr. Chairman. Mr. Hawkins, yesterday the Veterans' Administration testified that the reduction of money to provide medical care to category C veterans would not affect care delivered to category A and B veterans and would not require wholesale turning away of category C veterans.

In your opinion, is it possible to reduce the budget for category C veterans without turning them all away and without hampering the care for category A and B veterans?

Mr. HAWKINS. No, sir. As I had mentioned earlier, I think that we would have no choice except to turn away the category C veterans if we are able to identify those. The problem that you get into, with our institution, is a lot of times you have those veterans who come in because they are older, they are more seriously ill and many times they come in by ambulance and you don't really have a chance to categorize those patients before you start rendering some life saving care.

So far, the category C numbers at our facility has been about 2 percent. The paperwork and the administrative process of determining eligibility has been really devastating and has influenced our ability to deal with category A and B veterans because of the paperwork and the time-consuming process.

As I mentioned earlier, I think the only solution to that problem would be to stop them at the door and that is going to be very, very difficult to do. In some cases, impossible to do. It is going to affect the morale, I think, of our physicians and our nurses which we are already having trouble recruiting, to have to deal with those moral issues of providing care based on category A, B, or C.

Mr. HARRIS. Dr. Goldsmith, would you like to comment on that?

Dr. GOLDSMITH. Yes, sir, Mr. Harris, I'd be delighted to. I would like to echo what you have just heard about the problem with identifying category C patients or being able to keep them out of the hospital but add to it as well, that in the opinion of many of us, the patients who fall into that category are actually essential for us in order to be able to retain the viability of our institutions. The reality is that if we were arbitrarily to have a reduction in workload that is represented by the category C patients of the order of 2 to as much as 8 percent, as you have just heard a moment ago, a proportionate reduction in the budget for our institutions would destroy those institutions.

Furthermore, since the category C patients as well include a variety of different kinds of disorders, distributed throughout the A's and B's as well, we need those patients in order to justify being able to provide the kind of subspecialty care that is needed by the patients who are in category A and B.

Perhaps I can give the example best by suggesting that in order to have a neurosurgery service, for example, one needs to have two neurosurgeons. One needs two neurosurgeons whether one is taking care of 5 patients per year or 150 patients per year. You cannot provide adequate neurosurgery service with no neurosurgeons. To cut out 5 percent on the average of our patient population severely begins to compromise our ability to take care of the remaining 95 percent.

Mr. HARRIS. Dr. Green?

Dr. GREEN. Mr. Harris, I have to echo what Dr. Goldsmith has said and indicate this very briefly. I have given you the impact of what would happen at a small rural hospital if indeed the proportionate reduction of 8 percent per year occurred. You must understand that 8 percent calculation is based on the number of people that appear for service, not the number of people that are accepted.

If indeed that happened, White River in 3 years would not be a hospital as you know it. It's that simple, if that progression were allowed to occur, in addition to the 1 percent, in addition to the redistribution of people for programmatic purposes.

Mr. HARRIS. Ms. Halley?

Ms. HALLEY. Well, as a professional nurse, and as a chief nurse, I really am not involved—would not be involved directly with patient eligibility. I can share with you, though, of the patients treated between October 1, 1986 and November 30, 1986—6 percent of them were in category C.

I don't feel that I am in a position at this point to address the eligibility question.

Mr. HARRIS. All right, my time is up. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Harris.

Mr. Ridge of Pennsylvania.

Mr. RIDGE. Thank you, Mr. Chairman.

Ms. Halley mentioned that they had closed some units or a couple of wards, and Dr. Green mentioned that it's certainly a contingency plan that he must address seriously.

Dr. Goldsmith, as president of the VA Chiefs of Staff, could you enlighten us as to whether or not among your colleagues that included in all contingency plans, if we continue to see the reduction in funding of FTEs and the 1 percent management efficiency reduction annually that the prospects for major across-the-board unit or ward closings is imminent?

Dr. GOLDSMITH. Yes, sir, I think that if you were to talk with chiefs of staff or medical center directors throughout the system, you would hear a very similar kind of plea from all of them; namely, that the staffing situation at very substantial number of our hospitals is such that although we don't have the authority officially to close any wards, the reality is that in many cases, we can't staff them.

At my own hospital, San Francisco, we are just opening a new intensive care unit which has 18 beds. I can only staff 10 beds. I simply cannot recruit nurses to maintain the intensive care units in a totally safe manner. That gets into a different issue, which is the special pay rates and some of the special problems that we have in the more expensive areas for living. But one of the problems that has occurred throughout the entire system is the response to the resource allocation methodology, so-called RAM, which unfortunately has had a devastating effect on many medical centers because of very significant reductions in the numbers of dollars available. When those are added to the 1 percent efficiency reduction, nonpriority workload reductions, and so on, which are always hitting us at different times during the year, it's perfectly obvious that we simply cannot continue to maintain a workload the same as last year if we have fewer people to do so.

Mr. RIDGE. Well, following along that same line, I recall, I think it was you, Mr. Hawkins, who mentioned in the Dallas-Fort Worth area, you see increasing demand and pressure on your health care delivery system. You've had a couple thousand more patients and many more outpatients.

Dr. Goldsmith, is that generally reflective of the condition and increased demand on the VA Medical Centers across the country, nationwide?

Dr. GOLDSMITH. Well, I can't speak for all medical centers, but of those with which I am familiar, the answer is absolutely "yes." The people I have spoken with have all experienced an increase in demand for patient care.

Mr. RIDGE. Can you speak generally and provide a patient profile? I mean are we now beginning to see the impact of the World War II veterans that—is it mostly in this area, or is it—can you give me a patient profile?

Dr. GOLDSMITH. I can't give you an overall profile, but I think it is very clear that a substantial increase is occurring from the World War II veterans who are now beginning to fall into the age range over 65, and as you are well aware, the older the patient, the more frequently they do require hospitalization, so that that is a continuing problem.

But one of the interesting things, it seems to me is, that we are getting an increasing number of Vietnam veterans as well into the system. In part, perhaps, this might be due to the success of the Outreach Programs which I think in many ways have been very successful; but in addition, it's due to the fact that the population as a whole is experiencing some real problems with the delivery of medical care, and the Veterans' Administration is the recipient of many of those patients who might otherwise have gone to other mechanisms of care, and now either cannot afford it, or are being turned away.

Mr. RIDGE. We focused quite a bit on the rescission, but would any of you care to make any other statements concerning other particular portions of the medical budget that adversely affect you in your ability to deliver services? We have focused in on the rescission, but any other aspects of the budget you care to comment on?

Mr. HAWKINS. Well, I particularly am concerned about the construction budget, because in our case, as I mentioned earlier, we are dealing with a 1939 building and a 1950 building. As I have indicated in previous statements, our workload is increasing and our medical center is approximately 500,000 square feet short of criteria in which to provide care in a correct and safe environment. We are deeply concerned about the fact that within the last 2 years OMB has knocked out a clinical addition project for our facility, which basically is a high technology tower that would increase the ORs (operating rooms), the intensive care units. We are deeply concerned that the project has been knocked out again in 1988.

Just last week I was up in our intensive care units. Every bed was filled. We had to cancel surgeries, including open heart surgery, because there were not enough intensive care beds and not enough ORs to get our patients through to provide the care.

So we are dealing with old facilities in many cases, and we have in our primary service area over 500,000 veterans, and I see the demand going up, and we cannot continue to provide care in an old building that needs to be modernized and expanded.

Mr. RIDGE. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. The Chair recognizes Mrs. Patterson from South Carolina.

Mrs. PATTERSON. Thank you, Mr. Chairman.

First of all, I would like to congratulate all of you for hanging in there. It seems that at a time when they are putting more and more pressures on you and asking you, as I have already, to admit constituents, that it is a very difficult time for you.

Because of my special interest in nursing, I'd like to ask some questions.

Yesterday the VA testified that the salary differential between the VA and the private sector was not the main reason for nursing shortage. I think I can understand where they're coming from, but I'd like your personal opinion, really, how important the salary is to our nursing shortage at the VA, and particularly your medical center, and maybe what you have learned from other medical centers.

Ms. HALLEY. My experience, Mrs. Patterson, is that economic-related issues are probably the primary reason for why nurses do leave our system. My experience at East Orange in just this past fiscal year, we had 62 nurses to leave our facility. Of those 45 who left, gave the reason that it was economically related to salaries or benefits.

Now when I say economically related, I don't only mean salaries, but benefits. The take-home pay of a nurse who goes to the private sector where her medical insurance might be fully paid, where her dental plan and prescription plans are available, that we don't provide for them, then her overall take-home pay is larger. So even though it might not be salary directly, it is salary or economically related.

Our salaries at East Orange are running at this time anywhere from $1,500 to $5,000 less than the community hospitals, and we do have special salary rates in place.

Mrs. PATTERSON. So do I hear you say, is it more difficult to get nurses to come or to get them to stay?

Ms. HALLEY. We have right now both a recruitment and a retention problem. Recruitment in that we are not able to recruit that younger nurse into our system, because I think when you are young in your profession, economics is important to you. You're probably paying off student loans or things of that nature. And so if you could go down the street and make $5,000 more at St. Michael's Hospital, I think that's the nurse's choice. And so we have lost those nurses.

We also are finding and experiencing a retention problem with some of our experienced nurses, who I normally call stabilizers. These are nurses who have been with the VA system for a long time, but who are finding that it's more attractive, for whatever reasons, predominantly related to reimbursement for tuition purposes for education, to seek other employers.

For instance. in some areas in our private sector, they are not offering only remitted tuition for the nurse, but also for her husband and for her child. And so if you are a nurse and you have a child that's entering college age, that's attractive to you. And even though you may have allegiance to the VA, I think sometimes those allegiances are injured by the fact that economics are important also.

Mrs. PATTERSON. I'm probably going to show my ignorance, but are you all allowed the flexibility that our public hospitals at home are allowed as far as giving nurses different scheduling, like weekends? I think there's actually a title that goes with this kind of swing shift where nurses can either work on weekends or can work during the week.

Ms. HALLEY. I think you're referring to probably the Baylor Plan. We do not have it at East Orange, although in certain areas throughout the VA system, I do believe it's available.

At East Orange, though, whenever you're experiencing a shortage of staff, it means that more nurses have to rotate to weekends, and more nurses have to rotate to evenings and nights, and that's a dissatisfier, and it's also a reason why people sometimes don't come to our system.

Mrs. PATTERSON. I just know at home that that's been very effective in getting the young working mother, you know, who could work on weekends, but did not want to work during the week.

Ms. HALLEY. We've tried to be very strategic, and we've even brought in people on an intermittent basis where they might be able to work 1 day a week, 2 days a week, and sometimes they do give us weekend coverage, yes.

Mrs. PATTERSON. Do you find the same problem with other staff, for instance the LPNs or LVNs? Is there the same problem of the salary and recruiting and retaining them?

Ms. HALLEY. The same problems exist, particularly for the LPNs. The turnover rates that we experienced last year, 18 percent of our RNs did turn over; however, 35 percent our LPNs turned over. It's the largest group in terms of recruitment that we have a problem with.

Our LPNs unfortunately, in the community, can demand up to $7,000 additional salary that we cannot provide them.

Mrs. PATTERSON. Are there certain areas of expertise that are harder to recruit? For instance, I heard Dr. Goldsmith talk about neurosurgery. Are there certain areas that are much harder to recruit in the nursing field?

Ms. HALLEY. Unlike some of my colleagues, I have not experienced the difficulty with recruiting critical care nurses. My critical care nurses budgeted positions are in place, and they're okay.

Our experience has been with general medical, surgical, floor, staff nurses. That's been our problem.

Mrs. PATTERSON. I guess my only question might be, I understand there are other problems with recruitment of staff. I've been very active with our pharmacist at home, and I understand that maybe that's an area of difficulty. Would you all agree that there is a shortage?

Ms. HALLEY. Yes.

Dr. GOLDSMITH. Yes, ma'am.

Mr. HAWKINS. Yes, ma'am. I think there is a shortage of pharmacist and physical therapists, and I think there is, at least in our part of the country, a real problem in recruitment of intensive care nurses.

I think, in my 25 years of experience in health care administration, we're fixing to see the largest crisis of nurse shortages nationwide that we've ever seen. I just picked up before I left two advertisements out of the newspaper, one a Dallas paper and one a Washington paper, that's offering a $1,000 bonus in Dallas for any nurse who will come to this hospital and work 1 year. In the Washington area, they're offering at this hospital a $5,000 bonus.

I think we're going to see in terms of the nurse shortage a tremendous competitive recruitment process. In the Dallas/Fort Worth area right now there is a total shortage of 800 nurses, and most hospitals have beds closed, including intensive care beds and OR rooms closed because they cannot staff.

So even though we don't have maybe a nationwide problem right now, it's just over the hill, I can assure you.

Dr. GREEN. Mrs. Patterson, we're in a similar situation. We have two things working against us. One is a rural setting. So ICU nurses are scarce as hen's teeth.

We cannot recruit occupational therapists because the competition in the area, a fairly intense medical environment with a major clinic associated with Dartmouth Medical School. I'm down two out of three occupational therapists with little prospect of being able to recruit to full staff within a year.

The same is true of physical therapists. They're as scarce as hen's teeth. Respiratory therapists, any specialty discipline, and, believe it or not, secretaries.

Frankly, on a dollar basis, a secretary is the most valuable individual in the hospital. At least they keep me afloat. And the competition is such that the young men and women are not going into secretarial schools anymore. And the dollar competition locally for secretaries is such that I just lost my secretary, and I had to say to her, "Go, because you have a better opportunity. You have children to educate. You have things to do. Go." And that hurt.

And that's the problem. If you do a sampling in the Nation of overall, there is a dollar discrepancy, those dollar discrepancies are minimized by averages. But in any given situation where you have competition developing for people, those dollar discrepancies occur immediately. The private sector can respond to dollar needs much faster than a Federal bureaucracy.

Mrs. PATTERSON. I'm sure my time is up. I just wanted to say that it's very appropriate that this happens to be the time when the nurses from all over the country are in our area, and I am going to be meeting with them Friday, so I will certainly express your all's concerns. And I would also like to just say in closing, it's a sad day when you have to worry about whether an elevator is going to operate or not in a hospital where you definitely need it.

The CHAIRMAN. Thank you, Mrs. Patterson. Your time has expired.

Mr. Hawkins, if you, for the record, could give us those two private advertisements for attracting nurses from wherever source, that might help us to look at the competition and what they're doing.

Mr. HAWKINS. I'll be happy to provide those, Mr. Chairman. They're not very good quality, but I also have a whole stack at the office that I can also provide you, if you'd like.

The CHAIRMAN. Without objection.

[The information referred to is returned in committee files.]

The CHAIRMAN. We have in the audience Ms. Vinnie Ferguson, who is the head of the nurses' programs of the Veterans' Administration. She's really the chief nurse in the VA. We appreciate her being her today.

Would she mind standing up?

[Applause.]

The CHAIRMAN. We appreciate the interest she has showed by being a part of this hearing.

Let the record show Mr. Jontz of Indiana was here.

Mr. Johnson of South Dakota.

Mr. JOHNSON. Yes, thank you, Mr. Chairman.

Dr. Goldsmith, for at least a third year, the proposed budget from the administration includes a 1-percent productivity improvement. I wonder if you would describe for me the parts of a medical center budget which would be vulnerable or subject to productivity improvements and describe some of the improvements that have been taken at your facility?

Dr. GOLDSMITH. Thank you, Mr. Johnson.

I'm afraid that finding the improvements that result from a reduction in budget is going to be very difficult. However, the portions of the budget that are affected by this 1 percent represent a very significant fraction of our total budget. It represents our fuel and utilities cost, the support of our—all of our support and service personnel, all of the special programs which are called passthroughs, but which, in fact, are not passthroughs because they are subject to this 1-percent reduction in productivity—for productivity—and perhaps most devastating at all, it also includes the salaries of the personnel, the clinical personnel, who are involved in research.

As you may be aware, one of the most salutary aspects of employment with the Veterans' Administration is the opportunity for many of our professional personnel to participate in a variety of research and teaching activities. Their research time is protected in the sense that that time is not counted against direct medical care but rather falls into the category of the so-called pass throughs or indirect costs. Theoretically, therefore, those should all be protected and therefore people, a portion of whose salary is included in that category, should be able to count on having that salary. Unfortunately, the 1-percent reduction for productivity affects those dollars as well.

One of the problems that occurs therefore is that when one has a number of protected programs, such as blind rehabilitation or comprehensive rehabilitation programs or the STAMP program which is the special team for amputation mobility and prosthetics and so on, a whole variety of programs which is often the case in many of our tertiary and more complex institutions, plus a number of individuals whose salaries must be protected because of their research time, the net result is that the 1-percent reduction for productivity must be levied against a much smaller fraction of the total number of dollars, which results therefore in the net reduction in fact of perhaps 2.5 to 3 percent on the portion which is vulnerable.

The portion which is vulnerable includes things like fuel and utilities, the engineers, medical administration service, the activities without which we can certainly not continue to operate our institutions.

Mr. JOHNSON. Thank you, Doctor. Is there any elaboration on the part of Dr. Green or Mr. Hawkins on that?

Dr. GREEN. No, sir.

Mr. JOHNSON. I wonder if I may ask one additional question of Dr. Goldsmith again. There have been a number of actions that require reductions in FTE at medical centers and these have included the productivity improvements, errors in target allowances, the proposed rescission and the proposed reduction of treatment for category C veterans.

What actions can you take at your medical center to respond to these reductions? I am specifically thinking of reductions in force, although I hope there are some other options.

Dr. GOLDSMITH. I wish there were other options. In fact, we have requested authority to conduct a reduction in force, although we wish we didn't have to, but the reality is that we anticipate that the San Francisco VA Medical Center will be $5 million short of the funds required to continue operating for the entire fiscal year, this fiscal year ending September 30.

There is no way, therefore, that we can continue to operate throughout this year with a $5 million shortfall, since in fact we are not allowed to go into a deficit. We must be at least one penny in the black by the end of the year.

The CHAIRMAN. Would the gentleman yield? Dr. Goldsmith, I believe you have as many AIDS patients as any hospital in the country.

Dr. GOLDSMITH. Yes, sir.

The CHAIRMAN. Briefly tell us, what does it cost to take care of those patients and if you are losing and short $5 million, what happens in that area?

Dr. GOLDSMITH. Thank you, sir. I appreciate the opportunity. The reality is that it costs us approximately $40,000 per year per patient with AIDS to take care of them. At the present time, we have over 120 patients for whom we are caring with AIDS and ARC and we anticipate on the basis of the number of patients and the rate at which the increase is incurring, that by the end of this fiscal year, we will be caring for 160 patients at a cost of $40,000 per patient, that means that it will cost us $6.5 million to take care of those patients this year.

Because of the DRG mechanism for funding, which is based on workload 2 years previously, I have actually gone back to fiscal year 1985 which is the year on which our funding is based for this year, to find out how many patients we were taking care of with AIDS and what their diagnoses were, and according to the calculations that I did, which went through every single patient, we will be over $5 million short this year in order to take care of AIDS patients. As you have just heard, that in fact represents our shortfall for the operation of the hospital this year.

That, we believe, is the reason that we are going to be in deficit this year unless some miracle occurs.

The CHAIRMAN. Do you have a research center at your hospital?

Dr. GOLDSMITH. Yes, sir.

The CHAIRMAN. Are you doing any research on AIDS at that hospital, since you have more of the patients than other parts of the country?

Dr. GOLDSMITH. Yes, sir.

The CHAIRMAN. You are doing some research?

Dr. GOLDSMITH. Yes, sir. As a matter of fact, Dr. John Ziegler, who is my associate chief of staff for education, is the director for all AIDS' clinical research in the entire city of San Francisco.

The CHAIRMAN. Do you think we will ever get a breakthrough?

Dr. GOLDSMITH. I certainly hope so.

The CHAIRMAN. Thank you. Mr. Davis of Illinois.

Mr. DAVIS. Thank you, Mr. Chairman. I first would like to subscribe to the chairman's remarks about veterans in category C, particularly decorated veterans having access to the Veterans' Administration hospitals, but I must admit that I am somewhat puzzled as I understand category C veterans. I would like clarification, I suppose from you, Dr. Goldsmith.

What would cause a category C veteran to approach the Veterans' Administration? Is it that he has fallen through the cracks, lacks private health care facility because the income level obviously is a criterion in that category, or is the nature of that contact with you in a catastrophic or radical, medical or illness posture? What is the profile of the category C veteran?

Dr. GOLDSMITH. Thank you. In fact, I think all of the things that you have mentioned plus one additional one that you did not mention. It is very clear in fact that in some cities, in fact the VA Hospital is the best or among the best medical care facilities in that community. I am very pleased to say that is the case in San Francisco.

Therefore, in many cases, these veterans prefer to come to the VA Medical Center even if they have the potential option of being able to go to other institutions. Beyond that, the problems that you elucidated, such as catastrophic illness, inability to cover the cost of medical care, which as you know has gotten to be quite substantial, it is not yet required by all employers to provide medical care insurance for their employees, although I understand that is being considered at the present time as an option by the Congress, and as a result, there are many patients who theoretically should be able to afford medical care but whose income perhaps is $21,000, who simply cannot afford medical care.

I might just mention that in that regard, some of our employees at the hospital who theoretically are making a very adequate income, I might mention that a GS-4, for example, in San Francisco, a GS-4 secretary who is single and has one child qualifies for Aid for Dependent Children.

Mr. DAVIS. Obscene. Let me ask you this, Dr. Goldsmith: Your title is president of the VA Chiefs of Staff. Is that correct?

Dr. GOLDSMITH. Yes, sir.

Mr. DAVIS. Have you been in contact with your association? If all of your members, all of your chiefs, were sitting at that table, would they so testify as to the disastrous effects as you have indicated of the proposed budget at this point in time, in terms of FTE reductions?

Dr. GOLDSMITH. I think it would not be fair for me to say that all of them would. I can only say that of those whom I have contacted, the response is 100 percent.

Mr. DAVIS. Thank you. I have no further questions, Mr. Chairman. Thank you, Dr. Goldsmith.

The CHAIRMAN. Thank you, Mr. Davis. Dr. Rowland of Georgia.

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Chairman. May I welcome my colleagues, Dr. Goldsmith and Dr. Green, as well as Ms. Halley and Mr. Hawkins.

I want to follow up on the line of questioning of Mrs. Patterson concerning the high turnover. You mentioned nursing personnel in the hospital, and it not being competitive with the private sector.

I think it was about 3 years ago that the VA was given authority to go beyond the wage scale in order to be competitive and in order not to have this problem but I don't believe there has been any request in the budget for funding to do this.

Do you have any idea why that hasn't been done?

Mr. HAWKINS. You are speaking in terms of special rates?

Dr. ROWLAND OF GEORGIA. Exactly, if you have a GS-15 or whatever and you are able under the authority that has been given to the VA to pay beyond what a GS-15 would receive, in order to be competitive in the marketplace.

Mr. HAWKINS. One problem with that authority has been that basically we have been told that if you ask for special rates and are given special rates, that you would have to absorb those additional costs yourself out of your own budget. However, they would be considered on a case by case basis by the VA Central Office. I think the general feeling is that solution is not a solution if we have to in essence reduce additional staff to pay higher salaries.

Dr. ROWLAND OF GEORGIA. My understanding is that the authority is given to ask in the VA budget for funds that wouldn't cause you to have to do that.

Mr. HAWKINS. I think that's true, sir. I could not speak factually in terms of the VA Central Office policy on that.

Dr. ROWLAND OF GEORGIA. Mr. Chairman, I would like to find out more about that. I wanted to ask this question yesterday but didn't get an opportunity to ask that of the Administrator. I would like to get that question answered.

The CHAIRMAN. All right. We will do what we can on that. Thank you.

Dr. ROWLAND OF GEORGIA. Let me move to one other area. You were talking about category C veterans. I understand the problem that you have with that. It certainly places you in a real bind. You don't know whether the person is sick enough to be admitted to the hospital until after they are examined and once you start examining a person, you are committed then. It certainly poses a very difficult problem.

It seems to me that in order to address this, while it is only 2 percent in some areas, for those number of veterans, it is higher in other areas, that you might have to have additional admission personnel, professional personnel, to assess that.

I recall, Mr. Chairman, in my home town of Dublin, that there was a patient that was not admitted that could have been a category C patient and the patient died and there was a lot of controversy about that. I can see where you could get into a lot of controversy by not admitting patients, but you have to examine them so you are in a Catch-22 situation, I believe, with this. I just wanted to make that comment.

Let me address one other thing. We were talking about DRG's a moment ago. You have paid on a model that is called RAM, I believe. I want to relate that to the DRG's in the private sector. There is a lot of controversy going on that you are not being paid comparable to what DRG's are paying private hospitals under Medicare.

Is that posing a real problem for you? Dr. Goldsmith?

Dr. GOLDSMITH. Yes, sir, Mr. Rowland. As a matter of fact, I appreciate the opportunity to respond to that. I didn't realize that was going to be a question but I just happened to have brought some data with me, because this was one of the things that we have become concerned about. With your permission, I would like to introduce this into the record. This is a graph of the reimbursement dollars to the San Francisco VA Medical Center for a group of surgical procedures which range in complexity and the dollars that would be reimbursed to the university hospital, which is otherwise very comparable to our San Francisco VA Hospital, for those same procedures, and the average difference between what we are being reimbursed and what the university would receive is 250 percent. The university receives two and a half times as many dollars as we do. Even though we do not include in our reimbursement, the sunk costs for buildings and indirects, I think everyone would agree that two and a half fold is far beyond what could possibly be accounted for by those additional costs.

Dr. ROWLAND OF GEORGIA. I see that my time has run out. Just let me comment. We have heard over the years about how the VA is wasteful, they keep patients in the hospital longer than they should. I think that refutes that very contention by other people that the VA doesn't do a good job. It looks like to me that the VA is doing a tremendous job.

Dr. GOLDSMITH. Yes, sir. As a matter of fact, I'd like to point out in that regard that our average hospital stay is 6.5 days, which is more than comparable with the best medical care in the community.

Dr. **Rowland of Georgia**. Thank you very much. Thank you, Mr. Chairman.

The **Chairman**. Thank you, Dr. Rowland. Mr. Applegate, the chairman of the Compensation, Pension and Insurance Subcommittee. The Chair recognizes the gentleman.

Mr. **Applegate**. Thank you, Mr. Chairman. I would say that most of the questions have been pretty well asked. You have covered a great variety of issues. I must commend you for coming into the committee. I'm sure this isn't the easiest thing for you to do in your positions, to come in and testify before the Veterans' Committee on the budget and expressing concerns in various areas and you painted somewhat of a grim picture.

Let me ask Ms. Halley. You were talking about your 872 beds in your hospital and you say that over the past 3 years, you have lost about 100 employees?

Ms. **Halley**. FTE's, that's correct.

Mr. **Applegate**. What is this in terms of beds? Can you still fully staff 872 beds? Have you been reduced?

Ms. **Halley**. We are in the process of a major construction project and consequently, some additional wards have been closed to accommodate swing units, so that as a unit is prepared for modernization, that unit then moves to another swing space area. At this time, we probably are having at least 80 beds less than what our operating capacity is, so somewhere in the neighborhood of 730 or so beds are actually available for occupancy.

Mr. **Applegate**. Will that be permanent?

Ms. **Halley**. I would hope not. Part of the need to close beds was due basically to the nursing staffing storage as well as to the reduction. I would hope that if we are able to once again recruit significant numbers of Registered nurses that particularly, one medical surgical unit, would be reactivated.

Mr. **Applegate**. It is actually a matter of funding?

Ms. **Halley**. It's very much a matter of funding; yes, sir.

Mr. **Applegate**. Of course, everything gets down to that.

Just one other thing. I'd like to ask you—I don't know whether you addressed it or not—an assessment of the budget that was presented to us yesterday by Dr. Custis—are you familiar with the budget that they presented to this committee that was in consortium with, I think, the Disabled American Veterans, the Paralyzed Veterans, the VFW and the AMVETS?

Have any of you had an opportunity to look at that, and can you give me your assessment?

Dr. **Goldsmith**. Yes, sir. I think that we've only had a few days to examine that budget, and therefore I personally would not presume to be an expert on it, and certainly not by comparison to the budget submitted by the Veterans' Administration.

However, it seems clear to me that from the narrative that was associated with many of the elements of that budget, I found the arguments that were made in it very compelling, and therefore I would personally be inclined to be very positively affected by the budget submitted by the PVA and the other veteran service organizations. But I'm not qualified to make a judgment about all of its elements.

Mr. **Applegate**. Does anybody else have any comments they would like to make on that?

Dr. **Green**. I would agree completely with Dr. Goldsmith's position. The budgets of that magnitude are extremely complex, and we don't have available to us all of the information that goes into the calculations. So to support specific dollar amounts, I don't think would be reasonable.

On the other hand, as Dr. Goldsmith said, the narrative makes sense. And recognizing that health care costs are predicted to go up 10 percent this next year by Touche Ross, I think it's a matter of orders of magnitude.

So I can support the narrative, but the dollar amounts, I just don't have the sophistication and have not had the time to analyze it.

Mr. **Applegate**. Is that pretty much the way everybody looks at it right now?

Ms. **Halley**. I happened to be present yesterday during the presentation, and even though I have not had the opportunity to analyze the budget, the one item that would allow for the addition or reactivation of the Health Scholarship Program is one that I think is outstanding. That program did allow us to bring new people into our system, and I think it certainly is one that we can certainly utilize again right now during a nursing shortage.

Mr. **Applegate**. Good. Thank you very much.

The **Chairman**. Thank you, Doug.

Let the record show that Mr. Mica of Florida was here and had to leave. Also Miss Kaptur of Ohio was here.

The Chair recognizes the gentleman from Illinois, Ken Gray.

Mr. **Gray**. Well, thank you, Mr. Chairman.

I want to apologize. We have a party caucus going on, and I missed your testimony, but I assure you I will read it in detail, and I want to join the distinguished chairman and the other members of the committee in welcoming the entire panel here this morning.

Mr. Hawkins, since you are a medical director, what percentage of service-connected disability do you require before giving out-patient treatment to a veteran?

Mr. **Hawkins**. I'm not sure, sir, we require any specific percentage, but the basic guideline revolves around 50 percent as a general rule.

Mr. **Gray**. It used to be 10 by law several years ago, and the OMB kept sending down more stringent criteria on admission, and the Marion Elmore medical center in my congressional district requires, as you've stated, 50 percent, for a veteran to be 50 percent service-connected, which means that if a veteran, say, in Vietnam broke a leg, and he's only adjudicated at 30 percent, he can't get any treatment.

Do you think this is fair?

Mr. **Hawkins**. Well, we have a hard time convincing our veterans who apply for admission that that's fair, and it certainly creates a lot of confusion among our eligibility clerks as well as our practitioners who are trying to provide care, and it is a very, very confusing law and entitlement.

Mr. **Gray**. Do you think this is a dollar-and-cents judgment that's been handed down, continuing to require a higher percentage of disability compensation for out-patient treatment, or do you think the 10 percent was fair, the basic law, a veteran having 10 percent entitled him to hospitalization or at least priority for a bed, and now it's up to 50 percent?

Mr. HAWKINS. Well, my personal feelings—and I can only speak from my personal judgment on that—I feel that any veteran who is injured in the service, irregardless of the percentage, should be treated for that disability.

Mr. GRAY. So we'd almost have to come to the logical conclusion it's a dollar-and-cents judgment on someone's part, either OMB or someone, in continuing to raise the amount of service-connected compensation that a veteran must have in order to be admitted or to get out-patient treatment. Wouldn't you agree that that must be the conclusion?

Mr. HAWKINS. I'm sure that is probably one reason.

Mr. GRAY. Well, thank you.

Let me ask you another very quick question. You stated earlier that the veteran population was continuing to increase. Now we know that the World War I veterans are almost all gone. The World War II veterans are dying off pretty quickly.

What category? Are you talking about Vietnam veterans? Are you talking about Korean veterans where the caseload is increasing, or is it World War II and the two subsequent wars, Korea and Vietnam?

Mr. HAWKINS. I think it's all three, sir. We're seeing a drastic increase in terms of the older veteran, the World War II veteran, particularly in terms of long-term care demands and catastrophic kinds of illnesses.

The other thing that we're finding is that, like in our service area, I mentioned 500,000 veterans, and I think nationwide out of the 28 million veterans, only approximately 5 million might use the system. So what we are seeing is a lot of people who have not used the system before now coming to the VA because of the cost of health care and the economy in some parts of the country.

So potentially a large number of veterans—a very, very large number of veterans—have never used the VA system, that are now coming to the VA system, and that's where I believe the increased workload is coming from. But we are also seeing an increase in Vietnam veterans and Korean veterans, who are now getting into the 30 and 40 and 50 age group, and as we all know, the older we get, we consume more medical resources.

But we do have a particularly serious problem with long-term care for our World War II veterans. For example, in Dallas, we, this year, were funded for 80 contract hospitalization beds in the community. We had 111 in-beds in the community on contract to start the year. We still have those, because the contract normally runs for 6 months. So the demand for long-term care is exceeding our capacity, because our nursing home unit is full, and we don't have the funds to place those people in the community nursing homes.

Mr. GRAY. Mr. Chairman, I see my time is up, but if I could ask one very brief question, because this happened in my district about 2 weeks ago.

We had a service-connected veteran who was a prisoner of war in Germany, who is a terminal cancer patient. The doctor at the VA hospital said, "There's not anything else we can do for you," pushed him out of the front door in a wheelchair. He died about 2 weeks later in a civilian hospital, and the widow now is saddled with several hundred dollars worth of expenses.

Is that your policy, any of you? Can you address that? What do you do with a terminal patient that you know is only going to last 2 or 3 more weeks? Do you shove him out or keep him there until he expires, or what is your policy on that?

Mr. HAWKINS. Just very briefly——

Mr. GRAY. My time is up.

Dr. GREEN. Is it all right if I answer that question?

I think that you have to be guided by basic humanitarian principle. And if the person is truly terminal, debilitated, can't go home, you keep him. You cannot make a disposition that's to the disadvantage of the patient in the end. You have to have an adequate alternative plan for that patient, Mr. Gray.

Mr. GRAY. In this case, the plan was to send him out into a civilian hospital. The wife has very meager means, so she's now saddled with probably several thousand dollars, because he was in intensive care for 2 to 3 weeks.

Dr. GREEN. You know the facts of the case, the specific case, better than I, sir. I have to answer hypothetically, since I don't know the case.

Mr. GRAY. That's not a general policy in your hospital?

Dr. GREEN. No.

Mr. GRAY. Thank you, Mr. Chairman.

Mr. APPLEGATE [presiding]. Thank you very much, Mr. Gray.

Mr. ROWLAND OF CONNECTICUT. Thank you, Mr. Chairman.

I apologize for being late, and I don't know exactly what ground has already been covered, but I just have two questions that I'd like to touch on, to Dr. Goldsmith.

We've heard a lot about contracting services out among all the hospitals. I was just curious, and I know what the case is in my neck of the woods, but I was curious as to whether that is increasing? If it is increasing, it's obviously going to be more expensive and take a toll on your budgets.

How can we avoid that, if we want to avoid that, and try to take some of the stress off of your individual budgets and enable you to give, of course, the best service possible also?

It's a very general question.

Dr. GOLDSMITH. Thank you, Mr. Rowland.

The problem that we have with contracting for medical care is that it usually results at a time when we do not have the capacity to take care of that patient within our own institutions. This is often the case now, increasingly the case, as a result of the shortages of nursing personnel, radiology technicians, occupational therapists, and physical therapists, et cetera.

It's gotten to the point where, as I mentioned a little bit earlier, we are unable to staff our entire intensive care unit. These are very serious issues, and what often happens is precisely what you've described, and that is, a patient who comes into the hospital, requires a special type of care, and cannot be taken care of by the institution. We must then be responsible for sending that patient to another hospital for care.

The cost is extraordinary. Just to give you an idea of the cost differential, our reimbursement through the DRG mechanism for coronary artery bypass grafts is in the neighborhood of $8,000. We were forced recently to send one of our patients to a private hospital for the procedure, because we could not accommodate that patient in our own hospital. The patient was in the hospital for 4 days, had the surgery, and returned to us as soon as we could find a bed. That 4 days cost us $36,000. That came out of our operating budget.

That means that, in effect, that was the equivalent of our having taken care of four patients with the same procedure. It's devastating. And the reasons for this are manyfold, but clearly the most important is our inability to attract and retain the number and quality of personnel. In San Francisco, the payscale differential is as high as 77 percent between the VA and the private sector.

Mr. **Rowland of Connecticut**. Let me just follow up on that. I would assume that many, if not most, of the VA centers are connected with another institution, many of them teaching hospitals, other medical centers. And I see sometimes a little competition there and sometimes an inability for the VA center to get into open-heart surgery, for example, and I think some of those problems stem from that.

I also hear from many employees a theme, and I've heard it from other employees across the Nation, not only in my neck of the woods, that basically there is not only that competition with the medical center, but there's also a feeling of many VA hospitals that they are run by that other medical center.

And I always try to differentiate between a legitimate problem and a so-called turf war or just hard feelings, and I want to know, in your opinion—and of course, it is your opinion, because I don't think you'll be able to back this up with an factual data—in your opinion, does that seem to be prevalent with many of the VA centers?

Do employees feel that there is too much intrusion or involvement with another medical center? Is it just a turf war, or are there some very legitimate problems?

Dr. **Goldsmith**. Well, I think probably the answer to all of your questions is "yes." But in terms of the bulk of our medical centers, I think the reality is that our medical centers, even with close affiliations with other institutions, retain their independence entirely. I can certainly speak for our own medical center, and although we have an extraordinarily close relationship with the University of California-San Francisco—in fact, all of our professional staff have faculty appointments at the University of California—there is absolutely no question whatsoever about who runs our hospital, and it is not the University of California. It is the Veterans' Administration.

And I think, in fact, that the University of California would often be delighted if they could run their hospitals as well.

Mr. **Rowland of Connecticut**. Thank you very much. Let me assure you, with many of the problems and comments that you've outlined today, that this committee will be willing to work with all of you and on behalf of you to rectify some of these problems.

Thank you very much, Mr. Chairman.

Mr. APPLEGATE. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. I have no questions. I just want to compliment the panel for their fine testimony before us today. I yield back my time.

Mr. APPLEGATE. Thank you, Mr. Evans. Mr. Evans is the new chairman of the Subcommittee on Oversight and Investigations.

Gentlemen and lady, thank you very much. But, Dr. Goldsmith, could you supply the committee with copies of the two charts, the DRG comparisons?

Dr. GOLDSMITH. Yes, sir.

Mr. APPLEGATE. You'll do that. Thank you very much.

[The information referred to appears at pages 504 and 505.]

Mr. APPLEGATE. Thank you all very much.

Dr. GOLDSMITH. Thank you.

Ms. HALLEY. Thank you.

Mr. APPLEGATE. And I would like the record to show that Mr. Smith of New Jersey was in attendance and Tim Penny of Minnesota.

The next panel that we have is Mr. Paul S. Egan, Deputy Director of the National Legislative Commission for the American Legion and John Sommer, Deputy Director, Veterans Affairs and Rehabilitation Commission of the American Legion.

Gentlemen, it's always good to see you come back before the committee.

Mr. EGAN. Thank you, Mr. Chairman..

Mr. APPLEGATE. Thank you. And, of course, I've been dealing with John Sommer for a good many years back in our days in Columbus, Ohio, so it's always good to see him, too.

Mr. SOMMER. Thank you, Mr. Chairman. It's good to see you.

Mr. APPLEGATE. And you may proceed as you wish.

Mr. EGAN. Thank you very much.

Mr. APPLEGATE. Let me just say this, too, if you have statements, they will be placed into the record.

STATEMENTS OF MR. PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION AND MR. JOHN F. SOMMER, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

STATEMENT OF MR. PAUL S. EGAN

Mr. EGAN. John will summarize the lion's share of our presentation this morning, but I'd like to make just a few comments.

First of all, on the proposals with regard to the Home Loan Program, we share what appears to be the unanimity of this committee that increasing the user fee from 1 percent to 2.5 percent is wrong and shouldn't be allowed to go forward.

We further believe that that 1 percent ought to be allowed to expire on schedule, September 30 of this year. But if that isn't possible, we certainly think it's appropriate to exempt first-time home buyers from the application of that fee.

Built-in efficiencies within the VA budget, because of reduced claims for compensation and pension and reduced claims for participation in the Vietnam era GI bill will save automatically, without doing anything, $277 million. I think that is more than enough to pay for the exemption.

The other matter that I want to bring to the committee's attention was raised yesterday and was raised again today to a greater extent. It concerns whether or not the VA's application of its resource allocation model, the DRGs, is appropriate.

We believe that the application of DRGs to the practice of in-patient psychiatry in the VA is completely inappropriate, because the model that they are using is an acute care model. It's being applied to chronic patients, and the result is premature discharge of people who should be hospitalized longer.

That notwithstanding, wittingly or unwittingly, the result of this application of DRG as to psychiatry in the VA is making a substantial contribution to homelessness among veterans in this country. It is for that very reason that last Thursday night, Senator Murkowski offered an amendment to a homeless bill pending at that time that would take $5 million of the $50 million transferred from one FEMA account to an account to pay for emergency food and shelter. The $5 million would be transferred to the VA for the purpose of contracting for halfway house care for veterans who are chronically mentally ill and discharged from VA medical centers.

In that regard, we certainly hope that this committee will do what it can to see to it that the House accepts that amendment. We think it is long overdue and it is one step in the right direction.

[The prepared statement of Mr. Egan and Mr. Sommer appears on p. 506.]

STATEMENT OF JOHN F. SOMMER

Mr. SOMMER. Mr. Chairman, I will begin with the legislative proposals contained in the budget proposal. The American Legion is supportive, of course, of the cost of living increases consistent with increases in the Consumer Price Index. We are opposed to indexing compensation and DIC rates. We are opposed to the change in the eligibility criteria in the plot allowance. We support the assumption by the Veterans' Administration of the veterans mortgage life insurance program and we strongly support budgeting of all benefit costs of the peace time GI bill by the Department of Defense.

Under the Department of Veterans Benefits, the budget proposal reflects a decrease in average employment of 296 FTEE. If these employment reductions are enacted, employment in DVB will have been reduced by well over 5,500 FTEE since fiscal year 1979. These losses in our experience are causing problems in the regional offices and are adversely impacting on the quality and timeliness of the delivery of benefits and services to veterans.

Typical OMB boilerplate is used to disguise the fact that there is an $8 million savings associated with this proposed reduction. In the Department of Medicine and Surgery, the level of staffing for medical care reflects a net personnel loss of 3,813 FTEE. We are totally opposed to any reductions in medical personnel. Further reductions in staffing will result in irreparable damage to the VA medical care system and erosion of the quality of care provided veterans. I think that was very adequately and very clearly pointed out by the preceding panel.

To the American Legion, the proposed rescission of $75 million in fiscal year 1987 and further reductions of funding in fiscal year 1988 based on the elimination of funding treatment of category C veterans is totally unacceptable. We feel this can do nothing but cause all veterans using the system to suffer.

Additionally, we do not believe that Congress intended for category C veterans to be eliminated from VA medical care during the development of the language of Public Law 99-272. This is another case we believe of OMB attempting to impose its will on Congress.

Under medical construction, although the construction budget reflects a nominal increase, we do have some concerns beginning with the fact that there are no nursing home care units included in the request. The only funds requested for nursing care are $4.5 million under minor construction for the conversion of acute care beds to nursing beds.

It is distressing to see only two replacement hospitals included in the projection. As we have stated in the past, OMB is only fooling itself by delaying the funding of badly needed projects.

We believe it is a mistake to reduce the State home funding, particularly when the Veterans' Administration is relying more on the State homes all the time. We would like to point out in fiscal year 1985 the funding was only $35 million. In fiscal year 1986 it was only $21 million. Last year, there was an increase. However, this year the proposal is to decrease the funding by $800,000.

Mr. Chairman, the American Legion considers the VA budget proposal not to be satisfactory and we look forward to discussing specific problem areas with the committee in the future.

Mr. APPLEGATE. Thank you very much, Mr. Sommer. Just noticing that you are stating that the American Legion is not convinced that the Department of Veterans Benefits can operate effectively at the projected level of employment. Are you talking about that which is contained in the President's budget or are you talking about at present levels? Are you talking about a restoration of those proposed cuts or an increase over and above the 1987 levels?

Mr. SOMMER. We would have to look at the possibility of the increase over and above the 1987 levels. What we were referring to in this statement is that we feel there should not be a decrease of 296 FTEE as proposed in this budget. We would be glad to furnish you with our feelings on the other figures for the record.

Mr. APPLEGATE. All right. One other thing is that yesterday there was four other veteran organizations that came in and presented a budget which the American Legion did not participate in. Can you give me an assessment of that as to how the American Legion views that and if you support the budget that was presented by Dr. Custis on behalf of the four veterans' organizations?

Mr. SOMMER. Mr. Chairman, we were not involved in the development of that budget nor are we totally familiar with its content. We do not have a position one way or the other on the budget other than the fact that we do commend the four organizations for the time and the effort that they put forth and the hard work they put forth in developing this proposal.

Mr. APPLEGATE. It seems like a pretty reasonable approach. I think that is some what of a consensus at least among some of those that I have talked with.

I thank you personally very much for being here.

Mr. Solomon?

Mr. SOLOMON. Mr. Chairman, first of all, I have already welcomed the witnesses earlier. I have some detailed questions but rather than taking up the time of the committee, perhaps we could have unanimous consent to submit them to the witnesses and maybe get their written answers from them, if that is permissible.

Mr. APPLEGATE. Absolutely.

Mr. SOLOMON. I pretty much am supportive of all the positions that have been stated in your written testimony and oral testimony, gentlemen, with the exception of the funding of the GI bill through DOD. We will have a difference of opinion on that. I have some pretty strong feelings on it. If it is kept in the VA, it remains a very, very important high priority issue, certainly in the eyes, I think, of all the committee members. Over in DOD, it becomes one of just thousands of issues. I really have a lot of concern about that. I know your reasons and they are partially valid, but we may have to sit down and talk about that one difference. Otherwise, we really do appreciate your testimony here. If it is all right, I will submit some questions later on.

Thanks very much for coming before the committee.

Mr. APPLEGATE. Thank you, Mr. Solomon. Chairman Montgomery.

The CHAIRMAN [presiding]. Thank you, Mr. Chairman. I wanted to ask the representative of the American Legion pertaining to the testimony they submitted today, where they recommended that the GI bill be funded by the DOD. Yet, in the Senate, they didn't have this testimony. It was in your testimony and as I understand it, you took it out. Why did you put it back in over here?

Mr. EGAN. I don't think either John or I are prepared to answer your question there because neither one of us were not directly involved in the preparation of that testimony. But I can tell you, Mr. Chairman, that our position is the same here as it is in the Senate, and that is that we prefer to see that program funded by the Department of Defense. We view the program not as a readjustment program but specifically as a recruitment and retention program.

We share with you the view that this program should be made permanent, however.

The CHAIRMAN. You are the only veterans' organization that is supporting the Office of Management and Budget. I hope you haven't joined their ranks.

Mr. EGAN. Certainly not.

[Laughter.]

Mr. SOMMER. Mr. Chairman, we have had a mandate on this for several years, that this organization supports the funding of the peace time GI bill by the Department of Defense because it is a recruitment and retention tool of the Armed Forces and also leaving the administration of the benefit in the Veterans' Administration because that agency has the expertise and the machinery in place with which to administer the program.

The CHAIRMAN. Did you support the post-Vietnam era veterans educational assistance? Did the American Legion support that?

Mr. SOMMER. The VEAP program?

The CHAIRMAN. No?

Mr. EGAN. We did support that program, Mr. Chairman.

The CHAIRMAN. THe VEAP program; you are correct. That clearly states that we hoped it would bring in young men and women, qualified people to come in to the service and it was mentioned in there as a recruiting tool. You supported it back in the Vietnam era, the VEAP program, but now you have changed your position and also under the chapter 34 Veterans Educational Assistance, which I believe you also supported. Is that correct, under chapter 34?

Mr. EGAN. I'm not sure, Mr. Chairman, if I understand what you are saying as constituting a change in our position.

The CHAIRMAN. Both of those bills did have recruitment and retention under the provisions of the law. As I understood it and understand it, the American Legion did support both chapter 32 of the GI bill and chapter 34 of the GI bill.

Mr. EGAN. Both of those programs were readjustment programs, Mr. Chairman.

The CHAIRMAN. We did the same wording. I don't believe you really looked at what we did.

Mr. EGAN. We believe, Mr. Chairman, the peace time GI bill program that is in place right now is a defense program rather than a veterans readjustment program. That's a distinction that our membership has made and has made consistently. We don't believe in the event this Nation finds itself in conflict, once again, and once again this Nation finds itself in need of a readjustment program for recruiting war time veterans, that this particular program will necessarily be the best program for those needs.

Mr. SOLOMON. Will the chairman yield?

The CHAIRMAN. I would be happy to yield.

Mr. SOLOMON. One of the problems that we have here is the difference between what we perceive to be a readjustment. We really feel so strongly about this that we probably would like to meet with your legislative group and discuss it with you because there is no question that it is a defense measure and that was one of the main reasons why it was enacted. It is also readjustment in the sense that when you take these young men, if they are going in the service, and I think it is 18 or 17 or 19, when they put in 3 or 4 years in the service and let's say they return to the private sector at that time, those young men are always 4 years behind their peers in the private sector.

Take a young fellow that graduated from high school at age 18, and then goes to college. Another young man goes in the Marine Corp. Four years later, that first fellow is already up the ladder of promotion. He is already up the ladder in earning capacity and the second man never catches up. That is what the GI bill is meant to do. It is to readjust and to let him eventually catch up with his peer who did not serve his country in the military.

Those are the things that make it very difficult for us to lose sight of that because over in the Defense Department and the Armed Services Committee, they are only going to concentrate on the defense of the country, which is fine. We want to concentrate on both and we really would like to make that argument to your committee.

Mr. EGAN. If I could respond to that for just 1 second, Mr. Solomon. We are well aware of the fact that there are readjustment problems that new veterans are encountering. However, these veterans are people who are now part of the All Volunteer Force. They are not people who are conscripted. They are not people who are faced with confronting their own values as to whether or not they should serve their country in a war time situation.

What you are saying about readjustment certainly applies to the Vietnam era veteran. It certainly applies because the GI bills without the service requirements that are now in place for most Americans, like Pell grants and NDSL and the rest, were not available to veterans during our period of conflict. But those things are certainly available to individuals today who are considering a military career. Do they want to go to college? Do they want to go in the military? Either way, there are programs in place that will permit them to go to college to be competitive.

Mr. SOLOMON. Good argument. We would still like to talk to you about it.

Mr. EVANS. If the gentleman would yield, we feel very strongly on this. I think we call it the Montgomery GI bill. That is how strongly we feel about it. I think the suggestion is good by the ranking member that we meet with you about those concerns, although I would have to seek clarification from the fellow former Marine here. I thought being in the Marine Corp for 4 years would put you ahead of being in college for 4 years.

[Laughter.]

Mr. EGAN. I would like to make the record clear, Mr. Chairman. We will not oppose making the GI bill permanent because you intend to fund it through VA. We are simply expressing our concern that it ought to be funded by DOD.

The CHAIRMAN. What concerns us, the American Legion is right in lock step with OMB. You are the only veterans' organization that has done that.

Mr. EGAN. There are a lot of things that could be said that are bad about OMB but in our view, this doesn't happen to be one of them.

The CHAIRMAN. Under chapter 30, the All Volunteer Force Educational Assistance Program, I think it is just a matter of you interpreting it differently from what we are up here. It says the purpose of this chapter are one, to provide a new educational assistance program to assist in the readjustment of members of the Armed Forces to civilian life after separation from military service.

You mentioned the Pell grants. I am kind of surprised, you get no obligation from those individuals and the Pell grant program is going to cost, and it is worthwhile, cost the taxpayers $4 billion this next fiscal year. We are getting a young man or woman to sign up for 3 years on active duty, yet we are going to give them less than $300 a month. You are objecting to taking it out of the VA program that ought to administer it. We are trying to get good veterans, better veterans for you in the American Legion. It looks like you don't want them.

Mr. **Egan**. Mr. Chairman, ours is a war time veterans' organization.

The **Chairman**. I don't believe your national commander feels the same as you do.

Mr. **Sommer**. Mr. Chairman, maybe I can clear something up here. We are under mandate. We are not just—Paul and I aren't sitting here making up the position of the Legion as we go along. We have a national convention mandate that was reiterated by the delegates to the 1986 national convention in Cincinnati on this.

The **Chairman**. That makes another good point. You ought to be careful, all these resolutions that jump up and you pass them and send them over here and then come up here and make testimony like this. I'm sorry I went too long, Mr. Chairman. I just get concerned. This committee knocks itself out for the American Legion and other veterans' organizations. We carry the water. We try to. We are spokesmen for veterans in the Congress. They ought to be careful when they come up here with testimony like this.

Thank you.

Mr. **Applegate**. Thank you, Mr. Chairman. Perhaps those mandates are negotiable. I think that the ranking minority member's suggestion is very good and I think you should take advantage of that. I think we should sit down and talk about it. I just hate to see the American Legion sitting out there as the lone wolf, so to speak. I think it is a matter of interpretation. I think there is very solid support among the members of the committee here. Of course, we fully intend and hope to see it through the Veterans' Administration on a permanent basis. We would like to certainly have the American Legion in step with that, too.

Mr. Evans?

Mr. **Evans**. No questions, Mr. Chairman.

Mr. **Applegate**. Mr. Rowland?

Mr. **Rowland of Connecticut**. Thank you, Mr. Chairman. I don't have any particular questions. I would really like to emphasize that the American Legion has done an excellent job in presenting some eight different legislative initiatives. I know there are many, many areas that we will be able to work together with you on and perhaps in the not too distant future, we will be able to straighten out some of the concerns that my colleagues have.

I want to compliment you on some very good proposals and a well prepared piece of testimony. Like so many issues where there has been some disagreements and some agreements, I think we are going to be able to work very well with you and hammer out some of the specifics.

I thank you for being here and look forward to working with you through the rest of the year.

Mr. **Sommer**. Thank you, Mr. Rowland.

Mr. **Applegate**. Thank you. Mr. Gray?

Mr. **Gray**. Thank you, Mr. Chairman. As a past commander at both the post and the district level, I want to welcome our two guests here this morning. I don't have any particular questions, just keep up the good work for the Legion.

Mr. **Applegate**. Mr. Davis.

Mr. **Davis**. No questions.

Mr. **Applegate**. Mr. Johnson?

Mr. **Johnson**. No questions.

Mr. **Applegate**. Mr. Dornan?

Mr. **Dornan**. Thank you, Mr. Chairman. I just wanted to welcome the witnesses also. I am new to this committee, although I'm not new to the Congress. I've been a long time member in good standing at the American Legion. My dad was a member as a World War I veteran with three wound chevrons, we call them Purple Hearts now, for 60 years until he passed away. As with the other gentlemen on the panel, I look forward to working with you. Thank you.

Mr. **Applegate**. Thank you. Mr. Jontz?

Mr. **Jontz**. I have no questions.

Mr. **Applegate**. Gentlemen, thank you very much for coming before the committee. We appreciate it.

Mr. **Sommer**. Thank you, Mr. Chairman.

Mr. **Applegate**. The next panel we have will be from the Vietnam Veterans of America, Michael Leaveck, legislative director with Mr. Richard Weidman, director of government relations and Thomas Sherwood, director of health policy and planning. Please come to the table.

Gentlemen, thank you very much for coming before the committee. Your statement will be made a part of the record without objection and you may proceed as you wish.

[The prepared statement of Mr. Leaveck appears at p. 518.]

STATEMENT OF MICHAEL R. LEAVECK, LEGISLATIVE DIRECTOR, ACCOMPANIED BY: RICHARD F. WEIDMAN, DIRECTOR OF GOVERNMENT RELATIONS AND THOMAS A. SHERWOOD, DIRECTOR OF HEALTH POLICY AND PLANNING, VIETNAM VETERANS OF AMERICA

STATEMENT OF MICHAEL R. LEAVECK

Mr. **Leaveck**. Good morning. Mr. Chairman and members of the committee, we are very pleased to be here this morning to offer our opinions on the fiscal year 1988 budget for veterans' benefits and services as presented by the Administration. I would also like to offer a special greeting and congratulations to the new members of the committee and offer our hopes for a productive period of service on the Veterans' Affairs Committee. We look forward to working with you.

At Vietnam Veterans of America, we are often asked by the media and by Capitol Hill staff and our own membership if the President's budget contains enough money for veterans' programs and services. The point should be made that the amount of money really isn't the essential question. The essential question is how that money is to be spent and whether or not it makes sense in cost effectiveness terms and in terms of priorities.

VVA's general position is that $27 billion is actually enough money to fulfill the mission of the Veterans' Administration, but that at the same time, we think that not enough money is being spent on some very vital services in the area of service-connected health care, rehabilitation and readjustment.

When this budget was unveiled by the administration, it was heralded as a budget that re-focuses resources and money on service-connected health care and general services to the service-connected disabled. We see very little reality behind that rhetoric. We see, for instance, that the elimination of nearly 3,000 FTE in the Department of Medicine and Surgery cannot rationally be accounted for by a more thorough implementation of the means test. It just doesn't make sense according to the VA's own projections. Nor will the RAM system or DRG's actually take care of how those cuts are to be made or implemented.

We find, particularly in the area of health care, that the budget represents generally less of the same. The budget could be characterized as just a scaled down version of previous health care proposals and it is actually more of the same in terms of a general health care system for veterans rather than building toward a system of veterans' medical care and veterans' medicine.

We are also unable to unfortunately support the alternative budget as presented jointly by the other veterans' organizations, although we are very grateful that they asked us for their support and at some point in the future perhaps we can work together with them and interject some of our ideas and priorities.

With regard to a couple of specifics and before Mr. Montgomery comes back, we should probably interject that we do support the chairman's philosophy in trying to keep both the budget and the administration for the New GI Bill with the Veterans' Administration. We do see the GI bill as a readjustment benefit, although we recognize that it is important for recruitment and retention. We also see the practical necessity of this committee and Chairman Montgomery who had practically everything to do with the New GI Bill being established, as being able to keep the control. We are very fearful of what might happen if the chairman lost some of the control he has now.

A couple of specifics, and this certainly does not exhaust our list of concerns, but it would be useful to point out a few specific concerns that we have.

We are very concerned that some of the items of the VA budget be actually spent for the purposes for which they were intended and appropriated. For instance, in the area of contract health care, we see a lot of purposes that contract health care money could be used for. In our testimony, we point out the need for contract health care in the area of post-traumatic stress disorder, halfway houses, and we note that a lot of contract health care money has been turned back every year and used for everything from computers or to make up for shortfall in personnel.

We very strongly oppose the addition of another 1.5 percent user fee on the VA Home Loan Program. We see this as nothing more than a tax on veterans who are attempting to buy a home. We see, by the way, the VA Home Loan Program as a very vital readjustment benefit.

We would like to echo some of the remarks of our colleagues from the American Legion in supporting the $5 million amendment to S.J. Res. 102, which would provide care for chronically mentally ill veterans. We think that is an important part of our whole list of priorities with Vietnam Veterans of America, in terms of taking care of homeless veterans, many of which, or most of which I would venture to say, are Vietnam veterans.

We also note with a great deal of disappointment that the administration did not request funds for the continuation of the Veterans' Jobs Training Act. Over the years, actually in 1983 there were more Vietnam veterans unemployed than in any other point in history. The employment problems of Vietnam veterans are by no means over. From 1983 to 1987 certainly has not been an adequate period to stabilize the employment histories and to get good stable economic footing for a lot of Vietnam veterans that are still unable to stabilize their employment histories.

We should probably also note once again, and for this point, I'm glad the chairman is not here, that we do very strongly suggest and remind and recommend the committee that we see the mission of the Veterans' Administration as set within a certain group of priorities and that service-connected health care, compensation for service-connected disabilities, readjustment and rehabilitation, really have to take precedence over a lot of the other items in the Veterans' Administration budget, particularly in health care.

Lest we be criticized again for harkening back to the Bradley Commission, which we have been reminded is a very old document.

I would like to point out that in 1974 the 20th Century Fund, convened another task force chaired by former HEW Secretary, Robert Finch, among whose members were Robert Ball, former Social Security Commissioner and Bill Driver, former VA Administrator.

I would like to read a quote from that report, and it reads "Present eligibility standards for veterans' benefits indiscriminately give preferential Government assistance both to individuals who sacrificed literally everything by war related total disability and to those who sacrificed little or nothing and left the service without any handicaps. Any rationale for veterans' benefits based on sacrifice or handicaps of service would in principle call for more discrimination in benefits based on actual individual experience."

Vietnam Veterans of America asks that this principle be foremost as guidance in your budget deliberations this year.

Mr. Chairman and members of the committee, that concludes our oral testimony and we stand ready to answer any questions you might have.

Mr. APPLEGATE. Thank you very much, Mr. Leaveck. I really appreciate your testimony and what it is you have to say. It is always of great use to us in our deliberations. I would just have one quick question here I would like to direct to Mr. Sherwood.

Mr. Sherwood, apparently among your many experiences that you have had, you have been a chief nurse in the Veterans' Administration. The question is, what is your view of a pending nursing shortage and what implications does it have for the Veterans' Administration? Does the Veterans' Administration have enough nurses?

Mr. SHERWOOD. Thank you very much for giving me the opportunity to speak to that. It is true, I certainly was a chief nurse in the Veterans' Administration. From that perspective, first, based on much documentation in terms of the National League of Nursing, in terms of the American Nursing Association and now even the American Hospital Association has come on board with the recognition that there is really and truly a very serious nursing shortage.

With respect to the number of nurses in the Veterans' Administration, in terms of adequacy, the Veterans' Administration employs currently somewhere around 31,000 RN's. It is interesting to note that this is a health delivery system and usually in those kinds of systems such as a hospital, as an example, there are usually more nurses than there are physicians. The Veterans' Administration, I believe, employs somewhat over 40,000 MD's. I find this rather interesting in terms of the mission of direct patient care, which is usually carried out by professional nurses and nursing staff.

I would say that I am not clear that the total number of nurses that are employed by the Veterans' Administration and the various medical centers, et cetera, are indeed enough. We certainly can see that there are sufficient shortages of nurses in the large medical centers. That is easily documented. Given the primary responsibility that nurses have and their desire to have some control over their practice and practices and other issues that confront nurses, this is having a dramatic impact on recruitment and retention.

Generally, as my experience dictates as a chief nurse, there is not enough nurses and the issues with respect to the amount of nurses are issues that relate to retention and recruitment. I thought that Ms. Halley gave a very good explanation from the point of view of a professional nurse on the issue.

Mr. APPLEGATE. Thank you very much, Mr. Sherwood. I appreciate that. Mr. Solomon?

Mr. SOLOMON. Mr. Chairman, again, I have some detailed questions which we would like to submit to you and have you get back to us in writing on details so we don't take the time here.

I just want to comment briefly on the Veterans' Job Training Act, because as you know, Marvin Leath, who was the subcommittee chairman at the time, I was his ranking member, along with Sonny Montgomery, developed that legislation. I think it turned out to be one of the best pieces of legislation we have had in a long, long time, particularly as far as Vietnam veterans are concerned.

It is the intent certainly of this member and I think all the members to see that program is not only continued for this year but that we re-authorize it for a couple more years at least and keep that program going.

We really appreciate your support and we look forward to you pushing everybody in the right direction on it.

I don't have any further questions. Again, I want to thank you for coming before the committee.

The CHAIRMAN. Will the gentleman yield?

Mr. SOLOMON. I would be glad to yield to the chairman.

The CHAIRMAN. I appreciate your bringing up the Vietnam Era Jobs Bill. You and Marvin Leath and with the VVA's help, it has been right on track. In fact, it is getting jobs for Vietnam veterans today. I want to congratulate the VVA and also you for bringing this up and putting it on the record. I hope we can continue to reauthorize it.

We found out, for the new members of the committee, that we had this recession about 5 years ago. As a group, the Vietnam veterans was the group having the hardest time getting jobs and that is what really created bringing all this legislation into being and it has worked well.

While I have the floor, if the gentleman would yield further, I want to thank the VVA for sponsoring the program we have on the GI bill and just like we have done in the bill, letting the Veterans' Administration fund it. When you fund it, you control it. If you turn it over to the DOD and they fund it, then it is taken away from this committee and the Veterans' Administration. Down the line, it is a readjustment program.

You know, your organization is a small organization but you are tough and you are active and you give me a hard time on occasion, but you get the job done.

[Laughter.]

Mr. LEAVECK. Not with any malice, I might add, Mr. Chairman.

The CHAIRMAN. I know that.

Mr. SOLOMON. Mr. Chairman, just reclaiming my time, I know that Wayne Dowdy is the new chairman of that subcommittee, and we are certainly going to look forward to working with him, too, because I know he is a strong supporter of that program.

Mr. APPLEGATE. Thank you. I would add my ditto to what Chairman Montgomery has said.

Before I go to the next, I will just say that Mr. McEwen of Ohio was here and I want the record to show that.

Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

I would like to focus on two areas and I have a limited amount of time, so if you could kind of restrict your comments, at least on the first question, because I would like to go more in depth on the second.

You say in your testimony that not enough is being spent for "vital service-connected health care, rehabilitation and readjustment." Could you elaborate a bit on that?

Mr. LEAVECK. Certainly, Mr. Evans. As you are well aware, we are very concerned with Vietnam veterans who might be suffering from post-traumatic stress disorder, and at this time, according to reports that we are getting through our chapters and from people who we know who are involved in these programs, there are 3- to 5-month waiting lists in some areas for admission into post-traumatic stress disorder wards. These are very severe and often in cases life threatening service-connected disabilities that are not being treated.

At the same time—and again, I hate to pick on certain programs of the Veterans' Administration, but in 1985 the VA did 25 liver transplants, many of which, I believe about 24, were cirrhosis related. Those transplants cost in the neighborhood of $150,000 each, but yet they spend less than one liver transplant's worth of money in alcohol awareness programs. So when we see situations like that, something is a bit akilter.

There is another juxtaposition of programs that you might want to look at. The VA is currently calling for under this budget a reduction of 200 FTEE in medical and prosthetics research. At the same time, the Veterans' Administration has sent personnel to El

Salvador, for instance, to teach the El Salvadoran military how to conduct a prosthetics program.

We really have to scrutinize and criticize that priority system.

Mr. EVANS. How many VA medical personnel are in El Salvador?

Mr. LEAVECK. We don't know. We understand that personnel have gone down a couple times. It is a very worthy cause but it just doesn't seem to fit within the priorities that we would like to see the Veterans' Administration operate under.

Mr. EVANS. You refer in your statement to the seeming intention of the VA to close down the Veterans' Center Program. I have just learned of a VA memo which I have received that includes a list of nine veterans centers which would be physically relocated into existing medical centers. I don't know how they can start picking out just nine, including a vets center in South Dakota, from Congressman Johnson's State, when they apparently haven't come up with the overall plan for the so-called translocation.

It seems to me they should come up with a comprehensive plan, at least, and give us on the committee the courtesy of sharing it with us before they start targeting centers for relocation. This has an impact, I guess, on what they are trying to do in the whole budget area and the general plan to close, I guess, 104 locations. I don't know if you have any comment on this, but we would like your comment.

Mr. LEAVECK. Yes, we certainly do. We have just learned of this list ourselves, and it is interesting. Once again, you juxtapose a couple of policy considerations here. The Congress has not yet acted to determine whether or not the program is going to be extended for another year. There was a proposal last year to extend the program entirely for another year, which actually got amended into a bill which provided for an extension of the wind-down period, but the beginning of the wind-down period is starting October 1, 1987. There is another bill in the hopper this year.

So Congress really has not been involved in the process of deciding to start closing down the program, and this list, from what we understand, are vet centers that are to be closed this fiscal year, not after October 1, 1987.

I also might want to point out that Rick Weidman, sitting to my right, is the Vice Chair of the Veterans' Administration Readjustment Counseling Advisory Committee. Mr. Weidman was not involved in the process of selecting those centers, nor was he informed of the decision officially that they intend to close nine centers this year. We just don't think that is an adequate policy decision-making mechanism.

Mr. EVANS. I am concerned because I don't think Congress has had much input, particularly when we passed in the Health Care Amendments last year an extension of the period for the orderly and gradual transition of the Veterans' Center Program from the storefront, basically, to the medical centers. We haven't been involved in that.

I know the Congressman from South Dakota has a great deal of interest as a new member of our committee on this. He hasn't had any input into this, and I will yield to him.

Mr. JOHNSON. Thank you, Mr. Evans.

I want to comment as well that I share the concern of Mr. Evans, I share the concern as well of Senator Daschle, a former member of this committee who is very much concerned about these storefront facilities. I have the impression that the removal of these facilities will have the same effect as closing them. I think these programs have been one of the more successful readjustment programs we have had to offer veterans. They offer psychological counseling, family services, job counseling and outreach services. They have been staffed by veterans with an acute sense of the need of other veterans, Vietnam veterans in particular, and their families.

We have two of these facilities in South Dakota. One of them now is on this list. There has to be some question about where the cost for the removal of these facilities is going to come from. It apparently is not appearing in the budget as it stands now, and how long is this hit list, really? I think we need more information from the administration. I think this is a display of abominable priorities we see coming at this stage, and I am looking forward to working with your organization on this issue.

Mr. LEAVECK. Mr. Johnson, I think Rick Weidman could probably give you a little insight as to the budget implications and to how the decision was reached.

Mr. WEIDMAN. There is no money in the budget for the move, as you correctly point out, Mr. Johnson, but the ostensible cost savings that would be effected by moving the Vet Centers onto the hospital grounds is less than 7 percent of the readjustment and counseling service's budget, in toto.

The second part of it that disturbs us is that, as Mr. Leaveck pointed out, the Readjustment Advisory Committee, of which I serve as vice chairman to the Administrator, not only wasn't notified of this but have been trying for a month to get an appointment with the Administrator, and I am sure that will happen in the relatively near future, to present the recommendations of that committee to the Administrator as to the future of the vet centers.

It seemed to us to be precipitous for the Administration to move to close nine—or whatever the number, in fact, may turn out to be—Vet Centers this fiscal year because, in fact, the Congress has approached this in a very deliberate and responsible manner, at least this committee certainly has. This committee has not yet made the decision as to how best readjustment counseling services can be delivered to Vietnam veterans by the Veterans' Administration.

It seems to us that the administration has jumped the gun and taken Congress' prerogative in this regard, sir.

Mr. EVANS. I am way over my time, Mr. Chairman. I just would like——

Mr. GRAY. Go right ahead, Mr. Chairman.

Mr. EVANS. Thank you. I would just like to conclude. The memo says that this identification of these medical centers is based on an agreement between regional directors and readjustment counseling service and represents a consensus on those sites with "the greatest potential for successful implementation."

It goes on to say that it is initially believed that the transfer to the medical centers can be accomplished with a minimum of unrest in the Vietnam veteran community. I think they are going to find this is not true.

I would like this memo entered into the record, if possible, Mr. Chairman, made a part of the record.

Mr. Gray. Without objection, so ordered.

[The information referred to appears at p. 372.]

Mr. Evans. I will be following up on this particular matter, working with the gentleman from South Dakota and anyone interested on the issue.

Thank you, Mr. Chairman.

Mr. Gray. Thank you, Mr. Chairman.

The gentleman from California, Mr. Dornan.

Mr. Dornan. No questions, Mr. Chairman.

Mr. Gray. Mr. Harris?

Mr. Harris. No questions.

Mr. Gray. Mr. Johnson.

Mr. Johnson. No questions.

Mr. Gray. The gentleman from Indiana, do you have any questions?

Mr. Jontz. Thank you very much, Mr. Chairman. As a new member of the committee, I would like to thank you for the welcome. I look forward to working with all of you.

If you could, I would like you to take a few minutes to elaborate on the reference you made in your testimony to the problems facing chronically mentally ill veterans, and what is and is not being done to address their particular needs.

Mr. Leaveck. As Rick Weidman is the Vice Chair, once again, of the Readjustment Counseling Advisory Committee to the Administrator of Veterans Affairs, I will defer that question to Rick.

Mr. Weidman. This care for the chronically mentally ill within the VA medical structure, particularly having to do with in-patient treatment, Congressman, gets into a very complicated area that you have heard something about from some folks who try and operate hospitals here earlier today, the resource allocation models.

Suffice it to say that until October 1 of this year, there was a "discount" placed on all neuropsychiatric DRGs of 20 percent. It was an arbitrary 20-percent discount. It has now been removed. However, there are other things in that formula called the+ "weighted work units" that have been shifted, so that neuropsychiatric care is still being discriminated against, particularly long-term diagnoses having to do with paranoid schizophrenia and other kinds of long-term psychoses.

So, 40 percent of VA inpatients, approximately—in fact, it is great than 40 percent now—have a primary or secondary diagnosis that is neuropsychiatric, yet less than 9 percent of the resources got to neuropsychiatry. What that does is it forces, it distorts the medical decisions that are made so that there is an over-reliance, in our view, on psychotropics and other kinds of things that basically maintain and "control" that patient, as opposed to putting that patient through a regimen and a series of treatments which will help that individual be restored to full, productive life in this society.

Mr. Leaveck. It should also be noted that while we have the storefront counseling centers, on the one hand, which allows for drop-in, individual and group counseling, and we have post-traumatic stress disorder inpatient treatment wards, on the other hand, which provides for a 5-month, very intensive regimen of counseling and therapy, there is really nothing in between. That is one point we make in our written testimony, that there really should be some expenditures of the contract health care money to provide for halfway houses for post-traumatic stress disorder affected veterans.

Mr. WEIDMAN. I might also point out, Mr. Jontz, that the $5 million that you heard referred to here earlier today for the chronically mentally ill homeless veteran, we believe that up to one-third—and all the figures that we have seen support this—that one-third of the homeless veterans on the street are, in fact, chronically mentally ill.

We believe that a lot of those folks are on the street because they were discharged prematurely and the discharge was DRG-driven. If you will, they were discharged inappropriately from VA facilities. There was no contract halfway house for that individual to go to because VA did not spend all the money allocated by the Congress to that function. Therefore, those individuals ended up on the street not able to care for themselves. You can walk over here to Second and D Street in Washington, to CCNV, and encounter some of those individuals.

Mr. JONTZ. Thank you.

Mr. GRAY. Mr. Leaveck, let me ask you a couple questions if I may. We had testimony earlier this morning from some of the Veterans' Administration directors as to the increasing load in the VA hospitals. Do you have any idea what percentage of the patient load of the VA hospital are Vietnam veterans?

Mr. LEAVECK. Not to my knowledge. I don't think there has been a study done. Perhaps Mr. Sherwood would be able to give you some handle on any anecdotal evidence that might be available.

Mr. SHERWOOD. I know of no actual or precise study to actually break out the number of Vietnam vets as opposed to other kinds of veterans, although I would imagine that the Veterans' Administration should be able to supply that data, given the tremendous data base that they have.

Mr. WEIDMAN. Mr. Chairman, I think Bob Lindsay is in the room, the Director of Operations, and in fact, the Department of Medicine and Surgery does keep those stats.

Mr. GRAY. He just departed.

Mr. WEIDMAN. I am sorry, but they do have it. As I recall, sir, it is in the high 30s. Roughly 39 percent of both inpatients and outpatients treated in 1986 were Vietnam vets.

Mr. GRAY. The reason I asked that question was I had 55 veterans in my district a few months ago call me who were turned away from the local medical center on the Agent Orange proposition, all of them Vietnam veterans, and you know the story of Agent Orange, the defoliant problem in Vietnam.

I am just wondering, and the reason I asked the question, whether or not the Vietnam veterans as a group is trying to do anything to help the Agent Orange patients, particularly those that are being turned away on the grounds that the VA is not recognizing that as a service-connected disability. They are put on a waiting list to get in and then the medical center is oversubscribed. They can't get in. So I was wondering. That is the reason I was trying to get an analysis of the veterans that are in the hospitals and what percentage may be turned away.

Mr. LEAVECK. Mr. Chairman, it should be made very plain that Vietnam veterans who seek help of a VA hospital for ailments or conditions that they believe are associated with Agent Orange and they claim that are associated with Agent Orange and if they served in Vietnam, the Veterans' Administration has to assign them a higher priority than category C, so that has to be factored in.

Mr. GRAY. At the Marion Medical Center, they are being turned away on the grounds that the dermatologists call it a skin condition, everything but adjudicating it as service-connected disability.

Mr. LEAVECK. Now, for adjudication claims, again, that is another story, and Vietnam Veterans of America has filed a lawsuit against the Veterans' Administration for, as we allege, their failure to live up to the intent of Congress in writing regulations that would provide for compensation for conditions associated with Agent Orange.

Mr. GRAY. You understand you have got to file a claim to be adjudicated before you can get that designation to go into the hospital.

Mr. LEAVECK. That is correct. In the 4 years since the passage of, was it, 98-542, there has not been one claim adjudicated to provide compensation for a various range of diseases associated with Agent Orange based on an Agent Orange exposure or an Agent Orange cause, so there hasn't been one Agent Orange claim approved since the law was passed by Congress.

Mr. GRAY. That is precisely my point. They can't be adjudicated as being service-connected, so therefore they are being turned away on the grounds that they are nonservice-connected.

Mr. WEIDMAN. Congress, in fact, has recognized medical care for those maladies that a lot of people believe are due to Agent Orange, including us, sir; so the fact that they don't have a service-connected disability, they are still supposed to be listed as category B, Mr. Chairman, and they are supposed to be served by the Marion VAMC or any other VA facility for treatment of those illnesses at a higher priority than nonservice-connected but not as high as service-connected, if you will. So they shouldn't be turned away.

Mr. GRAY. I don't know whether you heard the testimony or not, but I elicited an answer from a VA medical director that he has been notified by OMB that you must be 50 percent service-connected in order to get immediate attention or outpatient care. So you can imagine, if you have got a nonservice-connected patient and you have got your Agent Orange cases and you have got the service-connected, if they are turning away service-connected compensation cases that have less than 50-percent disability, you can imagine what the Agent Orange patients gets. That is the reason I am trying to bring this out, because I think this is a big gap in the VA's adjudication process, and I think your veterans are being discriminated against.

I see that my time is up. Any other comments at all from the witnesses?

Mr. **Leaveck**. No, I think one point should be clarified that was alluded to earlier, when the chairman said that the Veterans' Jobs Training Act is a very valuable program and that it should be continued and that veterans are being put to work under that program right now.

The point should be made that as of a few weeks ago, the program is out of money, and the Veterans' Administration has failed to ask authority for reprogramming some money that they had left over. So there are no more Veterans' Jobs Training Act slots being made available for unemployed veterans.

Mr. **Gray**. Do you support re-funding of the Vietnam Veterans' Training Program?

Mr. **Leaveck**. We certainly do, and we will be working very ardently in that cause in the months ahead.

Mr. **Gray**. And also the GI bill?

Mr. **Leaveck**. That's correct.

Mr. **Gray**. Well, if there are no further questions—our distinguished friend from West Virginia, Mr. Staggers, has come in, and we'd be delighted to recognize you.

Mr. **Staggers**. I appreciate it, Mr. Chairman.

I'm sorry I'm late. There's a lot of committee organizations and such going on.

I did read your testimony; I'm sorry I missed it.

Mr. Leaveck, you note in your testimony that the Administration has not requested funds for the Veterans' Jobs Training Act.

Is that still a needed program, and what's the current status of the program?

Mr. **Leaveck**. Mr. Staggers, as you were coming in, we were just once again reiterating the point that at this point, the Veterans' Job Training Act is out of money, and the Veterans' Administration has failed to make the request for reprogramming of money, and they've also failed to include a request in the fiscal year 1988 budget proposal for more funds for that program.

There is kind of an interesting anecdote that I'd appreciate if Mr. Weidman could share, as he has been intimately involved in the actual agency implementation of the program.

Mr. **Weidman**. As you know, Mr. Staggers, even though the appropriation is at the Veterans' Administration and the disbursement of reimbursement to employers is handled by the Veterans' Administration, it is the Department of Labor Veterans' Employment and Training Service that actually carries out the program.

On January 5 of this year, we were at a meeting at the Department of Labor where the Department of Labor was premiering a film extolling the virtues of the Veterans' Jobs Training Act and how effective it was, both for employers as well as for the veterans involved, when the word came that the program was going to be shut down because it was out of money. They were all dressed up and did not have the monies to carry out the program. It wasn't until January 7, when hurriedly VA called the veterans' organizations together to brief us, and on January 13 the program formally was suspended.

Unfortunately not all of the word has gotten to the field, so it's been a rather ragged performance to the point where the Readjustment Advisory Committee to the Administrator is going to be, at the April meeting, considering the Department of Labor/VA working agreement. It's not working, quite clearly, as the people involved at all points of the process were not notified. Some part of the money has been, in our view, improperly sequestered by the Department of the Treasury, the "old money," as they call it, and the VA General Counsel never even saw fit to write a letter to them and say, "This doesn't make any sense. This is part and parcel of the same program that the Congress enacted when it was worked on so diligently by Mr. Leath and Mr. Solomon and the rest of the committee some years ago."

Mr. STAGGERS. So we, as legislators, have still more of a job to do.

Mr. WEIDMAN. I'm sorry, sir?

Mr. STAGGERS. As legislators, we still have a job to do.

Mr. WEIDMAN. Yes, sir.

Mr. STAGGERS. One other question, once again looking at your testimony and not really hearing—I hope I'm not retreading over old ground—but do you think the VA's resource allocation model, which I understand to be a DRG trim-point-driven model, works to provide greater cost efficiency in the hospital systems?

Mr. LEAVECK. Mr. Staggers, that question I'll defer to Mr. Tom Sherwood, who is our director of health policy and planning.

Mr. SHERWOOD. I would suggest that the DRG model, the RAM model as the VA calls it, the entire system really needs to be closely reviewed. When one looks at DRG, which is supposed to be a prospective payment system based on models that we've come to understand from the private sector, it is primarily a fiduciary-driven tool—that is, it's based on trim points, based on a diagnosis for current treatment, and then costs are based in terms of those trim points for the given diagnosis, and that's how a medical facility receives its third-party reimbursement.

Secondly, after then being a fiduciary-driven tool, it is, of course, a matter of the quality of medicine or quality of health care that is practiced in the institution, and clearly in the private sector, there has been some concern expressed with respect to a prospective payment system, how much does it, in fact, impede the quality of care?

I would say, looking at all the literature, that still has not been answered.

In the Veterans' Administration, however, this tool, very much like previous tools, such as the problem-oriented medical record, such as quality assurance, seem to be used politically in terms of meeting objectives that perhaps relate to the Congress or relate to the substantiation of the budget, but not in terms of the way the program is implemented in the private sector.

The instrument in the Veterans' Administration first uses information that is already past—that is, information based on 1 or 2 years of experience that has already occurred with respect to taking care of patients. Yet the appropriations, the dollars that support those systems, are based on the future—that is, the budget must be put together in terms of what the following year's budget will bring, doing here in 1987 for 1988. We have these extremes of the past and the future, not addressing the currency that is normally associated with the prospective payment system as used in the private sector.

To say, therefore, that we are using a RAM DRG trim-point-driven system in the Veterans' Administration to assess both cost and to also assess the quality of what we're doing for patients really does not appear to be what, in fact, is the case. I think the entire model needs to be reviewed in terms of the reality of practice outside of the system and the way prospective payment systems are really used, in terms of a costing device and the necessary association with the quality of care, and not as an instrument which ultimately results in the kind of obfuscation of what, in fact, is going on.

This was kind of alluded to in the presentation we heard this morning. I have, from my own experience, found in the field—that is, where the medical centers are—that there is considerable confusion among medical center directors as to exactly how this instrument is supposed to operate. That is, a medical center will find out for a given fiscal year that they will be minus *x* number of dollars from their target allowance.

This apparently is supposed to relate to the DRGs, while at the same time they are not told how they can make that up or what adjustments they need to make in their resources to overcome the difficulties that that implies.

So it is a major issue, given the amount of dollars involved—we are talking of billions of dollars—and it needs to be aligned with respect to the service organizations' understanding of it, the Congress' understanding of it, and the Veterans' Administration, so that the Administrator, right down to the practitioners who absolutely implement the care, know exactly what the objective is, based on the larger arena of a prospective payment system, if that is the way the Veterans' Administration, as a public system, wants to go.

But there is a problem with a public system versus a private system in the implementation of such a tool under these conditions.

Mr. STAGGERS. Mr. Chairman, this raises some serious problems. I would hope that the Subcommittee on Hospitals and Health Care would undertake a study of this, and we can get to the bottom and find out just how the system is working.

I appreciate the information. Thank you, Mr. Chairman.

Mr. GRAY. I thank the gentleman from West Virginia.

Due to our very expert staff, we do have the exact statistics of the number of Vietnam veterans that were using the facilities. This is out-patient and in-patient care. 18.8 percent of all patients last year admitted to VA hospitals or used the facilities were Vietnam veterans.

Mr. STAGGERS. Thank you, Mr. Chairman.

Mr. GRAY. The Chair would like to state to our distinguished friend from West Virginia that the subcommittee will hear that matter that the gentleman brings up. It's very important.

Mr. STAGGERS. I appreciate it, Mr. Chairman.

Mr. GRAY. Are there any further questions?

[No response.]

Mr. GRAY. If not, the committee stands adjourned.

[Whereupon, at 11:39 o'clock, p.m., the full committee meeting was adjourned.]

APPENDIX

STATEMENT OF THE HONORABLE THOMAS K. TURNAGE
ADMINISTRATOR OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
February 3, 1987

Mr. Chairman and Members of the Committee, I appreciate this opportunity to appear before you today to present the Veterans Administration (VA) FY 1988 request of $27.6 billion in new budget authority to fund medical, compensation, and other programs for the nation's 27.7 million veterans, eligible members of their families, and survivors of deceased veterans.

Included in this amount is an appropriation request for $27 billion, a net of $81.3 million related to proposed legislation and $529 million in permanent authorizations and offsetting receipts. The VA's FY 1988 request represents an increase of approximately $548 million from funds currently requested in FY 1987. Budget outlays for FY 1988 are estimated at $27 billion. Average employment (FTEE) is expected to decrease by 3,126 from the 1987 current estimate to a level of 218,005.

At the outset, I would like to assure those of you who have expressed concern that insufficient resources are being requested for FY 1987 and FY 1988 that this budget will enable the Veterans Administration to meet its goals and objectives. Quality medical care for America's disabled and needy veterans is one of this administration's highest priorities.

The budget being requested for FY 1988 provides ample resources to furnish no-cost care to all service-disabled veterans who request it, as well as to former prisoners of war and veterans exposed to toxic substances and radiation. No-cost care would also be provided to veterans of wars prior to World War II and those receiving VA pensions. Among other veterans, funding would be provided for no-cost care for all earning less than $25,325 per year (for a veteran with one dependent; $20,260 for a single veteran). Funding would not be provided for the care of those whose annual income exceeds these levels. This administration believes that as a rule when veterans' illnesses are completely unrelated to their military service and they are financially able to provide for their own health care, they should do so. However, in locations where resources and space remain available, the VA will continue to furnish care to non-service disabled veterans with incomes above these levels. This practice will allow the VA to concentrate its efforts on service-disabled veterans and those least able to finance the cost of their own health care. It carries out the provisions of the Veterans Health Care Amendments of 1986, which established the current set of eligibility criteria for veterans' health care.

Consistent with this patient care policy, the 1988 request contains a rescission proposal which would eliminate funding that would otherwise be used during the last five months of FY 1987 for hospital, outpatient, VA nursing and community nursing services paid for by the VA for the care of higher income, non-service disabled veterans.

I will now summarize the VA's FY 1988 request, highlighting the budget issues for each of the major accounts.

Compensation

The 1988 budget requests $10.4 billion to provide compensation payments to 2.2 million veterans and 323,000 survivors. The 1988 funding request reflects the full year impact of the 1.5 percent compensation rate increase provided to all recipients on December 1, 1986. In 1987, a supplemental of $80.2 million is required to fully fund this rate increase.

Legislation is being proposed to index compensation benefits to the annual change in the Consumer Price Index. Enactment of this proposal would guarantee that all compensation recipients are provided a full and timely cost-of-living adjustment. It is currently estimated that the first such "automatic" cost-of-living adjustment, effective December 1, 1987, will be 3.5 percent and cost approximately $301 million.

Pensions

The 1988 budget submission includes an appropriation request of $3.8 billion. This amount is needed to provide payments to 1.2 million eligible recipients. The 1988 caseload estimate is 69,000 below the 1987 estimate. The caseload reduction reflects the recent trends in this program. Although it is anticipated that the number of veterans age 65 and older is expected to double during this decade, improvements in retirement benefits as well as other income sources will result in the continued decline in pension caseload.

The 1988 budget request includes the full year impact of the 1.3 percent cost-of-living increase provided to Improved Law recipients in December 1986, as well as an estimated 3.5 percent cost-of-living adjustment which would be effective in December 1987. The cost-of-living adjustments to eligible pension recipients, by law, are based upon the actual change in the Consumer Price Index.

Burial Benefits and Miscellaneous Assistance

In 1988, an appropriation of $141.7 million is requested to support operations in the Burial Benefits and Miscellaneous Assistance appropriation. The $13 million increase in 1988 is primarily due to an aging veteran population.

In addition, legislation is proposed making the plot allowance eligibility consistent with that for the burial allowance. Under this proposal, the plot allowance would continue to be paid for burial of veterans who were on either the compensation or pension rolls and for certain indigent wartime veterans whose burials would otherwise be at State expense. It is estimated that this proposal would reduce 1988 funding requirements by $31.3 million.

Legislation is also proposed authorizing the funding of the veterans mortgage life insurance program in the Veterans Insurance and Indemnities appropriation rather than the Burial Benefits and Miscellaneous Assistance appropriation. The funding of the Veterans Mortgage Life Insurance program is more appropriate under the Veterans Insurance and Indemnities appropriation which funds other insurance programs. This proposal would result in no overall change in appropriated funding.

Readjustment Benefits

An appropriation of $625.7 million is requested to operate this program in 1988. This funding level is $115.4 million below the 1987 appropriation level. The reduction in the appropriation request is primarily the result of a declining caseload as more Vietnam-era veterans either exhaust their education benefits or reach their 10 year delimiting date. Although the training workload is estimated to decline, this appropriation request will provide education benefits to nearly 183,000 Vietnam-era veterans, over 43,000 dependents, and vocational training to 24,500 veterans. The 1988 request also includes $20.4 million to fund the basic benefit costs to veterans training under the All-Volunteer Force Educational Assistance program (New GI Bill). The appropriated funds for this program, in addition to the transfer of over $121 million in supplemental and reservist benefits from the Department of Defense and Department of Transportation, will fund the training of 19,400 veterans and almost 124,000 reservists.

Legislation will be proposed establishing the All-Volunteer Force Educational Assistance program as a permanent recruitment program for the Department of Defense. In this regard, it is proposed that the Department of Defense budget for all costs associated with this program. Under this proposal, the $20.4 million in basic benefits, included in the Readjustment Benefits appropriation request, would be appropriated to the Department of Defense. These basic benefit funds would be transferred to the Veterans Administration along with the supplemental and reservist benefit payments. It is important to note that the VA would continue to administer all benefits associated with this program.

Loan Guaranty

An appropriation of $389.8 million is required in 1988 to support operations in the Loan Guaranty Revolving fund. This appropriation request, which is based upon continuance of the 1 percent funding fee, would fund nearly $2.7 billion in obligations estimated for 1988. It is estimated that approximately 340,000 loans totaling $26.7 billion will be closed in 1988.

In addition, the 1988 budget proposes several initiatives to improve the management and operation of all government credit programs. Specifically, in the loan guaranty revolving fund, the VA would begin liquidating $900 million of its loan portfolio currently valued at $1.1 billion. The budget request anticipates that in 1988, $300 million of portfolio loans as well as $668.4 million in vendee loans would be sold without recourse.

The FY 1988 budget request includes several legislative proposals. None of the proposals will alter the program's primary goal which is to provide affordable housing to veterans with no down payment. The primary purpose of these proposals is to make the program solvent thereby eliminating the need for future appropriations and to improve credit management.

First, it is proposed that the 1 percent funding fee, which is scheduled to expire on September 30, 1987, be increased to 2.5 percent on June 1, 1987. The increase in the funding fee is necessary to obviate the need for an appropriation. Given the expected foreclosure rates, we believe that a 2.5 percent fee is necessary to keep the program solvent over time. The cost of this fee can be paid during the length of the loan and, if financed, would increase the veteran's average monthly payment by less than $10.

Legislation is also being proposed to have a lender/borrower negotiated GI interest rate. This means that future interest rates would be established by the lender and veteran as is done in other Federal programs and the private sector. This Administration has long believed that the Government should not regulate mortgage interest rates when the private market can do so more efficiently.

Two legislative proposals extend initiatives included in the Deficit Reduction Act of 1984. First, the VA proposes to continue the methodology used currently in determining whether or not to acquire a VA guaranteed property in foreclosure. These standards require that the cost of holding a property be considered in determining whether or not VA should acquire a property. By making this decision on a cost basis, VA can continue to manage the Government's resources devoted to the fund efficiently. Second, the VA proposes to increase the number of properties sold for cash. Existing legislation requires that at least 60 percent, but no more than 75 percent of acquired properties be sold with vendee financing. The legislative proposal, if enacted, would limit the vendee financing of property sales to between 40 percent and 60 percent.

General Operating Expenses

The budget request for General Operating Expenses is $816.1 million and 17,751 average employment for the operations of the Department of Veterans Benefits, the Department of Memorial Affairs, and the various staff functions of our Central Office. The 1988 funding request reflects the full year impact of the 1987 costs related to a 3 percent pay raise for Federal personnel, effective January 4, 1987. In 1987, GOE is able to absorb its pay requirements within existing resource levels.

However, a supplemental appropriation of $9.2 million is being requested to finance the increased 1987 costs related to the new Federal retirement program established by Public Law 99-335, Federal Employees' Retirement System Act of 1986.

The Department of Veterans Benefits (DVB) is requesting $551.3 million and 12,619 FTEE in 1988 which is an increase of $33.4 million in budget authority and a decrease of 296 FTEE from 1987. The budget proposes additional funding to continue DVB's comprehensive modernization program which will improve the delivery of services to veterans and their dependents. The 1988 budget includes $34.4 million for the modernization of the benefits delivery system. Projected savings as a result of this investment will enable costs to be recovered by 1994, three years after implementation is completed. This submission also requests $8.9 million to convert to a new files storage system. It is estimated that this project will have a $40 million savings potential to the Government over a 20 year life cycle. At this time, it is anticipated that the St. Paul and Philadelphia insurance operations will be consolidated. Such a consolidation will show annual savings of $1.7 million when it is completed in FY 1989.

The Department of Memorial Affairs is requesting $47.7 million and 1,187 FTEE for the management of the national cemetery system for eligible veterans, active duty military personnel and their dependents. This is $3 million above and 2 FTEE below the 1987 level. It is expected that total interments will increase by 2.8 percent and headstone/marker applications processed will increase 2.7% over 1987 levels. Resources required for the activation in 1988 of the new national cemetery in Florida are also included in this budget.

In the General Administration activity, the 1988 request is $217.1 million and 3,945 FTEE which is an increase of $10.4 million and a decrease of 159 FTEE from the 1987 level. Initiatives are primarily in the data processing area and include PAID Redesign System Internal Specification Study ($1.1 million), CALM modernization for the design study and additional disk capacity for VA's financial systems ($0.5 million), and LOG I Redesign for the analysis and design of the automated supply system ($2.2 million). All three of these initiatives will provide resource savings which will more than offset the investments.

A new staff office, the Office of Systems Planning, Policy and Acquisition Control, is being established under the direction of the Associate Deputy Administrator for Management. This new office will establish ADP policy and evaluate ADP planning and procurement throughout the VA.

Medical Care

The Veterans Administration is requesting just under $10 billion for the Medical Care appropriation in 1988, an increase of $414 million over the 1987 estimate with an average employment level of 190,330 FTEE. Supplementals of $74.7 million and $131.6 million are being requested in FY 1987 to finance increased costs related to a 3 percent pay raise for Federal personnel, effective January 4, 1987, and the new Federal retirement program established by Public Law 99-335, Federal Employees' Retirement System Act of 1986, respectively.

Through its 172 hospitals, 231 outpatient clinics, 120 nursing homes and 16 domiciliaries, the VA provides a nationwide medical care delivery system designed to meet the special needs of America's veteran population. On the average, VA patients are older, have lower incomes and are more often in need of more comprehensive care than their counterparts in the general patient population. In the VA, inpatient health care is linked with outpatient care and specialized care modalities to provide an integrated, comprehensive system of health care delivery for eligible veteran beneficiaries. The 1988 budget request provides funding for the medical care and treatment of 1.4 million inpatients and 20.4 million outpatient medical visits.

A number of program and management initiatives are included in the 1988 budget request. These initiatives are designed to ensure that appropriate resources are available in the Medical Care appropriation to provide quality treatment to service-connected veterans and non-service connected veterans who cannot afford to pay for their care.

In 1986, legislation changed eligibility procedures for veterans seeking health care. Under the new law ("The Veterans Health Care Amendments of 1986", Public Law 99-272), three categories of eligibility (A, B and C) were established:

-- Category A consists of service-disabled veterans, former prisoners of war, veterans exposure to certain toxic substances or radiation, veterans of wars prior to World War II, and those receiving VA pensions, as well as those non-service disabled veterans with annual earnings of less than $18,234 (for a veteran with one dependent, $15,195 for a single veteran).

-- Category B consists of those non-service disabled veterans earning between $18,234 and $25,325 per year (for a veteran with one dependent, between $15,195 and $20,260 for a single veteran).

-- Category C consists of non-service disabled veterans with earnings above the Category B levels.

These income threshold amounts increase by $1,013 for each additional dependent. Within these categories, VA has an obligation to provide hospital care and may provide outpatient and nursing care to veterans in Category A. The VA may provide hospital, outpatient and nursing care, within existing available resources, to veterans in Categories B and C, providing that veterans in Category C agree to make a copayment.

Consistent with the new law, the 1988 budget provides funding for the care of those veterans for whom the VA has an obligation to provide medical care, those in Category A and, in addition, it also provides funding for the care of those veterans in Category B. The VA will continue to furnish care to non-service disabled veterans with incomes above the Category B levels in locations where resources remain available.

Included in the 1988 budget request is a proposal to rescind $75 million in 1987 budget authority and reduce 1987 employment by 1,400 FTEE. This proposal, which is consistent with the President's budget for 1988, would eliminate funding that would otherwise be used during the last five months of FY 1987 for hospital, outpatient, VA nursing and community nursing services paid for by the VA for the care of higher income, non-service disabled veterans.

Also included is a change in mission of the VAMC Walla Walla, Washington with the closure of all inpatient beds and the establishment of an outpatient clinic at Walla Walla to report to the Spokane VAMC. The mission change is being proposed for several reasons including a very low and declining volume of inpatient workload, and a very low percentage of service-connected veterans being treated. Veterans in the vicinity of Walla Walla will continue to be served on an inpatient basis at the Spokane VAMC, and on an outpatient basis at the Walla Walla outpatient clinic.

The VA is also proposing a mission change for the Miles City, Montana VAMC which calls for closure of inpatient surgery beds, a reduction of 32 acute medicine beds, establishment of 10 alcohol treatment beds, and an increase in 32 nursing home care beds. The VA Medical Center will retain an outpatient surgery capability and will expand outpatient care activities at the Billings, Montana Outpatient Clinic. The net affect of these changes is to alter the character of the Miles City facility from predominantly acute care to predominantly extended care.

A mission change is also proposed for Big Spring, Texas which consists of shifting the emphasis on the types of services provided by this facility from primarily acute medical, surgical, and psychiatric care to primarily extended care. The proposed mission change would eliminate inpatient surgical capabilities and would establish limited outpatient surgical services. To complement the extended care mission, long-term psychiatry and nursing home care beds will be established.

The Veterans Administration's extended care programs encompass a broad spectrum of care. One of the areas where the needs of the aging veteran will have a dramatic impact over the next few years is in the demand for nursing home beds. One method of providing additional long-term care beds is to convert existing beds to nursing home care beds. In 1988, $12 million and 335 FTEE will be transferred from the hospital to the nursing home care activity for the conversion of 282 beds to nursing home care. A realignment of resources from hospital to nursing operations as well as new activations will add an additional 854 FTEE and $35.3 million to this amount for a total increase above the 1987 level of $47.3 million and 1,189 FTEE.

The 1988 budget provides for increases of $10.9 million and 1,981 FTEE for facility activations, including the activations for new nursing homes I just mentioned. Activated projects increase the quality of patient care through improved or expanded operational capabilities. Many projects include additional, or an expansion of, sophisticated specialized services and new high technology treatment modalities. These projects may involve construction of new space and include workload increases such as outpatient visits and expanded clinical support services.

Medical And Prosthetic Research

The 1988 request for Medical and Prosthetic Research is $198.8 million, an increase $6 million over 1987 after excluding the one-time transfer of $20 million from the Department of Defense. The 1988 employment request of 4,417 FTEE is 225 under the 1987 level, but 16 FTEE above the 1986 actual.

Supplementals of $1.9 million and $1 million are being requested in FY 1987 to finance increased costs related to a 3 percent pay raise for Federal personnel, effective January 4, 1987, and the new Federal retirement program established by Public Law 99-335, the Federal Employees' Retirement System Act of 1986, respectively.

Medical research will provide funding in heart disease, schizophrenia, spinal cord injury, diabetes, cancer, aging, alcoholism, and related problems of Vietnam-era veterans, former prisoners of war and female veterans including an epidemiology study of women Vietnam veterans as mandated by PL 99-272.

Rehabilitation research funding will provide significant emphasis in priority areas of prosthetics/amputations, spinal cord injury and sensory aids. Health services research will continue its efforts in management and service initiated research.

Medical Administration and Miscellaneous Operating Expenses (MAMOE)

The 1988 request for this program is $49.8 million and 595 FTEE, an increase of $7.6 million and 4 FTEE over 1987. Supplementals of $736,000 and $345,000 are being requested in FY 1987 to finance increased costs related to a 3 percent pay raise for Federal personnel, effective January 4, 1987, and the new Federal retirement program established by Public Law 99-335, the Federal Employees' Retirement System Act of 1986, respectively.

Because of recruitment difficulties in some areas and in some specialties, the Veterans Administration proposes to reactivate the Health Professional Scholarship Program. Funding is requested for $6 million to support 211 one-year awards and 84 two-year awards to nursing and physical therapy students. Funds are also requested to allow for the collection of morbidity/mortality data to be used in the development of standards required by the VA Health Care Amendments Act of 1985.

Grants For Construction of State Extended Care Facilities

As a part of VA's long-term care policy, budget authority of $42 million is requested for 1988 for grants to States for the construction or repair of State homes for the care of aging veterans. These funds will allow VA to continue shifting the mix of VA-sponsored care towards cost-effective State nursing home alternatives. Currently, because of the increased funding, we are projecting that, in 1988, 3 to 5 States that have not previously participated in the State Home Program will receive grants. The increase will provide 371 additional nursing home beds and 450 domiciliary beds as well as 12 non-bed related renovation projects in seven States.

Construction

The 1988 request for the construction appropriations is $525.7 million, an increase of nearly $37 million or 7.5 percent over last year. Of this amount, $400.6 million is for major projects at medical centers, regional offices and national cemeteries.

Major construction funds are proposed for fifteen sites, including the bed replacement and modernization project at Dayton, Ohio, and the environmental improvements, patient and nursing home care buildings project at North Chicago, Illinois. The budget request also includes funds for clinical addition projects at Huntington, West Virginia and Jackson, Mississippi. Funding is also included for gravesite development of the Northern California National Cemetery.

Design funding is being requested for a new VA medical center at Palm Beach as well as for replacement and modernization projects at the Pittsburgh VAMC and the Atlanta VAMC.

In minor construction, the 1988 request of $121 million represents an increase of $40 million or 50 percent over the FY 1987 funding level. Minor construction includes a General Administration limitation of $42.7 million, reflecting the realignment of the Facility Engineering, Planning, and Construction (FEPAC) office with the Office of Construction to create the new Office of Facilities.

An increase of $1.2 million in the limitation for the expenses of the Office of Facilities is being requested in FY 1987 to finance increased costs related to a 3 percent pay raise for Federal personnel, effective January 4, 1987, and the new Federal retirement program established by Public Law 99-335, Federal Employees' Retirement System Act of 1986.

An appropriation of $4.1 million in new budget authority is requested for the parking garage revolving fund in FY 1988 to fund the parking garage for the Huntington, West Virginia clinical addition project.

Closing

Mr. Chairman, in closing, I am committed to the accomplishment of the VA's mission to provide veterans the care, support and recognition they have earned in service to this Nation. Our budget request reflects both a commitment to meeting the needs of our veterans as well as a concern for fiscal restraint. I appreciate the continued support and guidance of this Committee. This concludes my introductory statement. My staff and I are available to discuss the details of this request and answer your questions and those of the Committee Members.

WELCOME

TO THE

VETERANS ADMINISTRATION'S

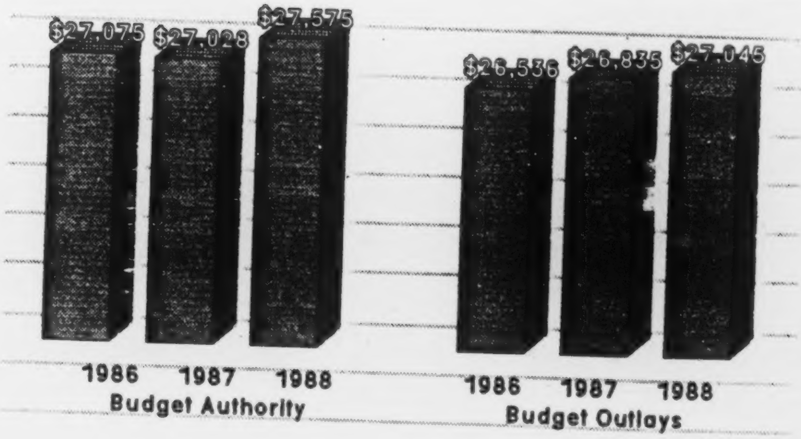
PRESENTATION OF THE

FY 1988 BUDGET

General

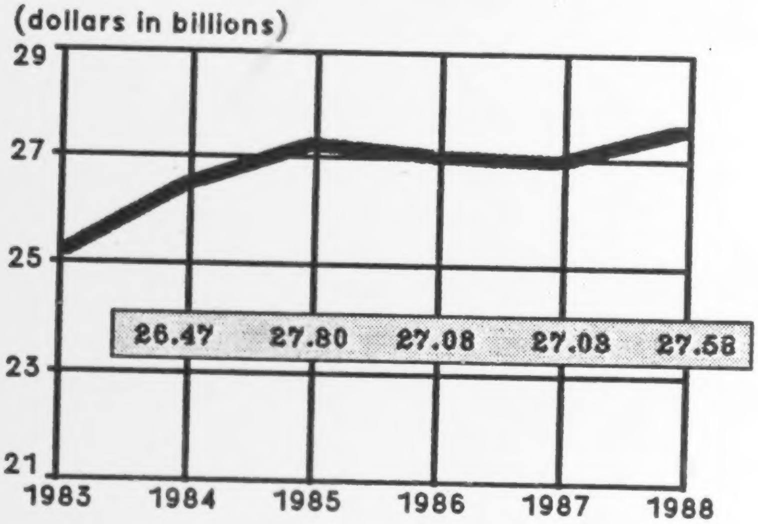
- The overriding concern governing the VA's budget has been to provide sufficient resources for the VA to meet its statutory and equity-based obligations for veterans benefits and health care while doing so in the most efficient manner possible, given the existing fiscal climate.
- Economic assumptions are as of December 8, 1986.
- Includes the impact of the new Federal Employees Retirement System (FERS) and the 1987 Pay Raise.

FY 1988 Budget



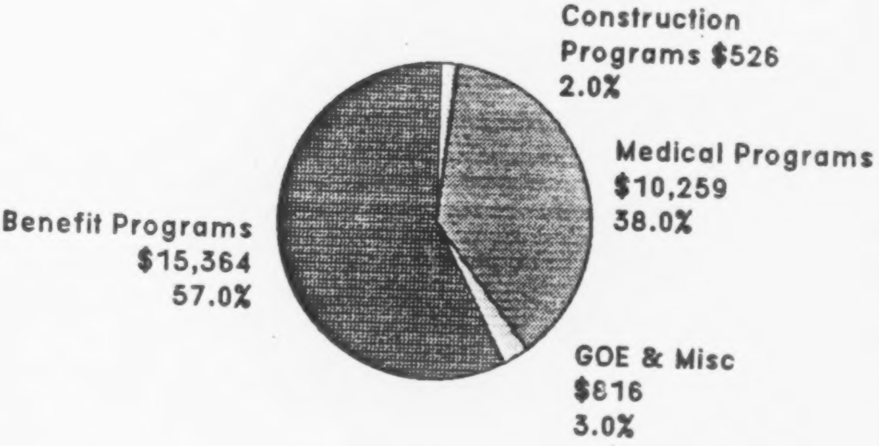
Total Budget Authority

1983 - 1988



1988 Appropriation Request

Distribution by Major Programs
(dollars in millions)



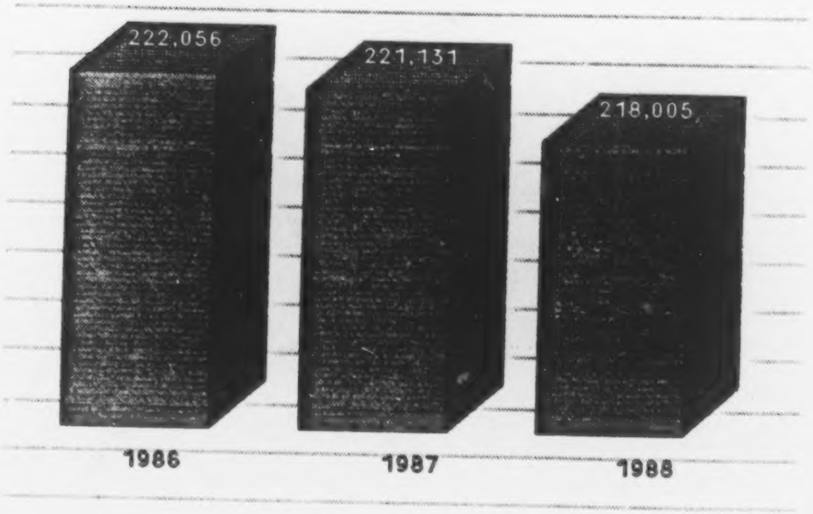
Total, VA $26,965

1988 Budget Authority

Requiring Action by Congress

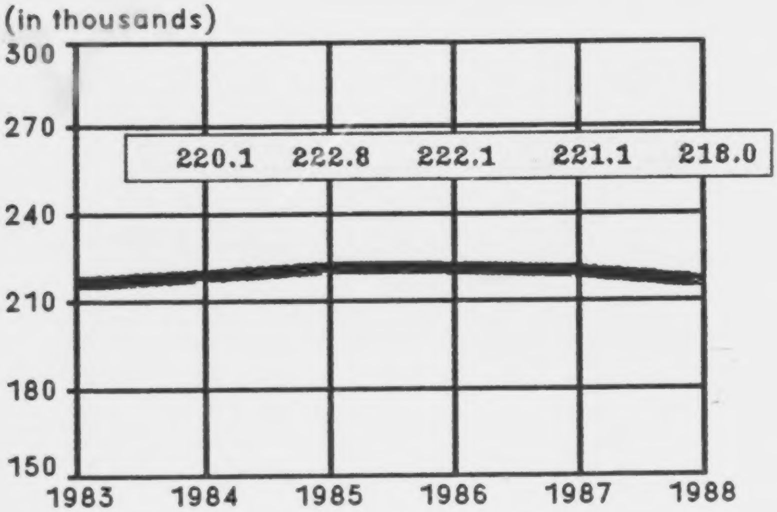
	($ in millions)
Appropriations Request (Existing Legislation)	$26,965
Proposed Legislation	-141
Total - Requiring Action by Congress	26,824
Permanent Authorizations & Offsetting Receipts	529
Proposed Legislation	222
Total, Budget Authority	$27,575

Average Employment



Total Average Employment

1983 - 1988



FY 1987 Supplemental Requirements

(dollars in thousands)

Program Supplemental	
Compensation	
COLA increase of 1.5% (12/1/86)	$ 80,200
Total, Program Supplementals	$ 80,200

Pay Raise Supplementals	
Medical Care	$74,695
Medical & Prosthetic Research	1,859
MAMOE	736
Construction, Minor Projects	(665)*
Total, Pay Raise Supplementals	$77,290

*Non-add (limitation increase for associated costs)

FY 1987 Supplemental Requirements & Rescission

(dollars in thousands)

Federal Employees Retirement System (FERS)	
Medical Care	$131,600
Medical & Prosthetic Research	1,024
MAMOE	345
General Operating Expenses	9,242
Construction, Minor Projects	(529)*
Total, FERS	$142,211

Rescission	
Medical Care (-1,400 FTEE)	$(75,000)
Total, Rescission (-1,400 FTEE)	$(75,000)

*Non-add (limitation increase for associated costs)

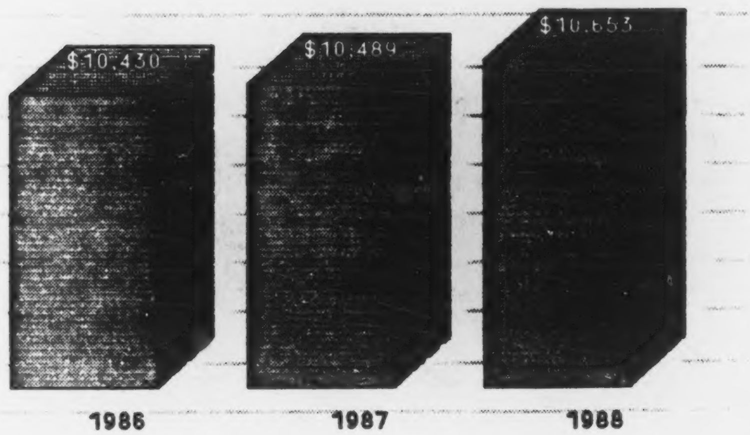
FY 1988 Proposed Legislation

(dollars in thousands)

Compensation:	
COLA increase of 3.5% (12/1/87)	$301,000
Loan Guaranty Revolving Fund:	
2.5% funding fee for guaranteed and vendee loans	-389,800
Burial Benefits:	
Standardize plot allowance eligibility	-31,300
Readjustment Benefits:	
DoD budgeting for New GI Bill	-20,400
Total, Proposed Legislation	$-140,500

Compensation

(dollars in millions)



Compensation

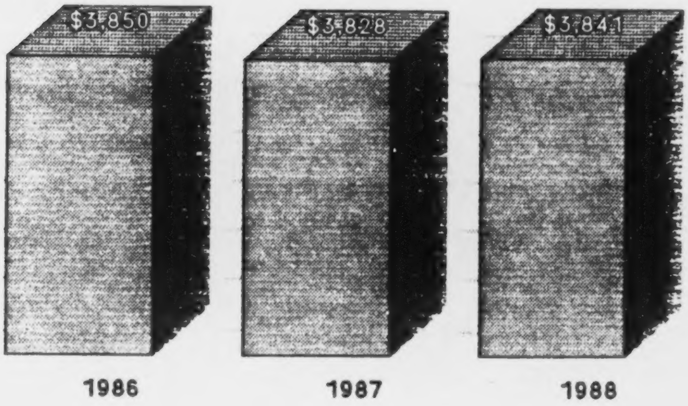
- A supplemental of $80.2 million is requested in 1987 to support the 1.5% COLA increase effective December 1986.

- Legislation will be proposed to index the annual change in the COLA to changes in the consumer price index. This proposal would guarantee a full and timely COLA to all compensation beneficiaries, including DIC dependents. It is estimated that the COLA effective December 1, 1987 will be 3.5 % and require $301 million in 1988.

- Total average casload is expected to be 2,524,900 in 1988.

Pensions

(dollars in millions)



Pensions

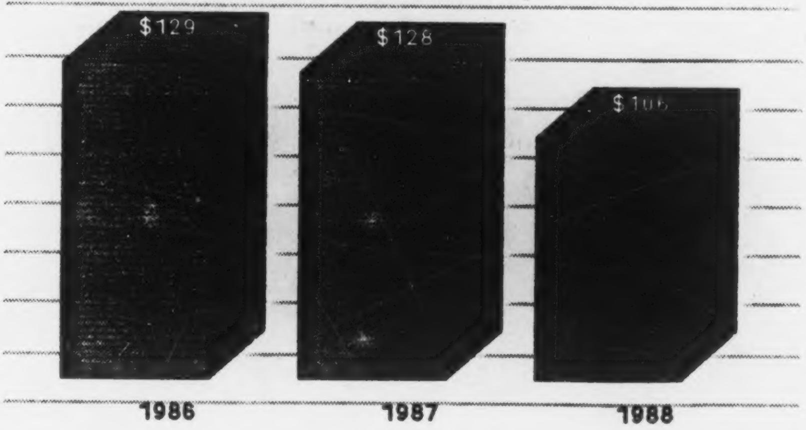
Included in the budget request **($ in millions)**

	1987	1988
• Cost-of-living adjustments of:		
1.3% (effective 12/1/86)	$33.4	$40.1
3.5% (effective 12/1/87)	...	92.3
Total	$33.4	$132.4

- It is anticipated that the pension caseload will total 1,235,000 in 1988.

Burial Benefits and Miscellaneous Assistance

(dollars in millions)

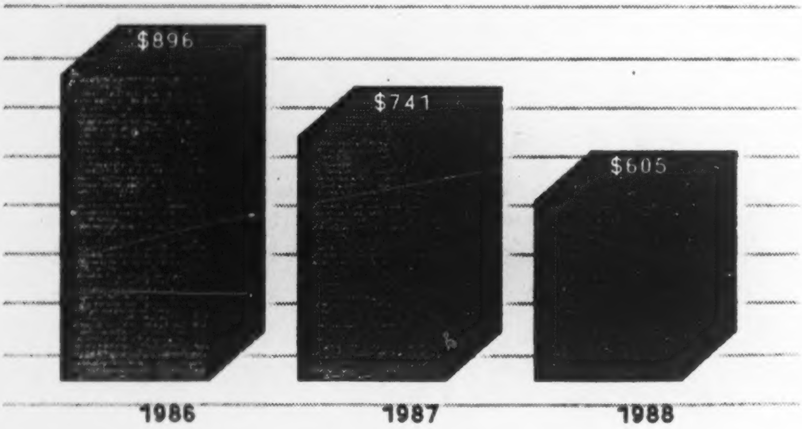


Burial Benefits and Miscellaneous Assistance

- Legislation is proposed standardizing the eligibility of the plot allowance with the burial allowance. Burial benefits will continue to be provided to service-connected deaths and veterans receiving either compensation or pension payments at the time of death.

Readjustment Benefits

(dollars in millions)



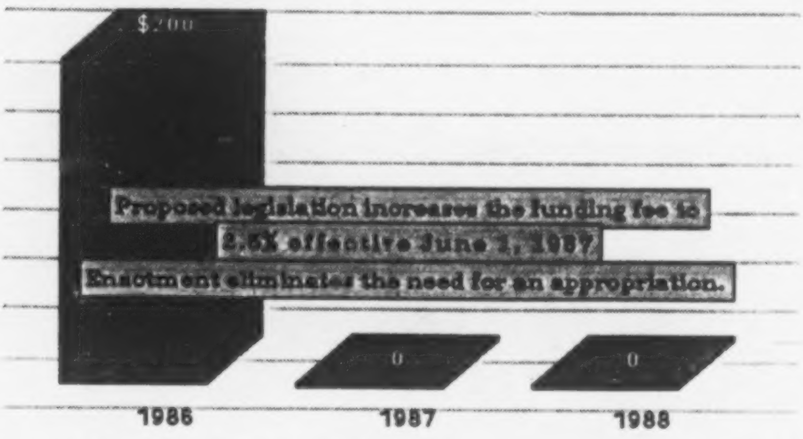
Readjustment Benefits

- The $136 million reduction in the 1988 funding level is the result of (1) an estimated 22% decline in Vietnam-era veterans caseload due to veterans either reaching their delimiting date or exhausting their benefits and (2) the continued decline in dependent caseload.

- Legislation is proposed authorizing DoD to budget for benefit costs associated with the New GI Bill. The VA would continue to administer all benefits associated with the New GI Bill. In 1988, this includes payments totalling $35.4 million to approximately 19,400 veteran trainees and $106 million to 124,000 reservists.

Loan Guaranty Revolving Fund

(dollars in millions)



Proposed legislation increases the funding fee to 2.5% effective June 1, 1987

Enactment eliminates the need for an appropriation.

Loan Guaranty Revolving Fund

- Legislation will be proposed increasing the funding fee to 2.5% on June 1, 1987. This increase in the funding fee would make this program self-supporting. Failure to increase the funding fee would require an appropriation of $390 million to support estimated 1988 activity.

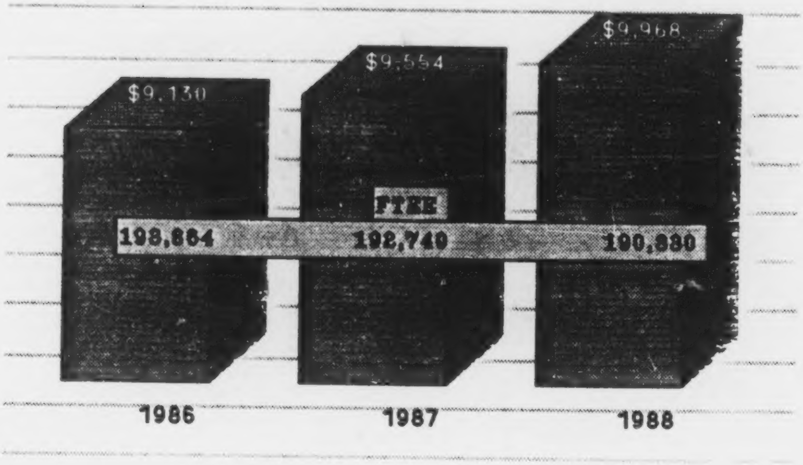
- Legislation will also be submitted enabling the veteran to negotiate the home loan interest rate directly with the lender.

Loan Guaranty Revolving Fund

- As a result of government-wide initiatives to more efficiently manage the credit program, the VA will:
  - o Begin selling, over the next three years, $900 million of the current $1.1 billion loan portfolio. In 1988, it is estimated that $300 million in the portfolio will be sold.
  - o Also, all future new loan sales will be made without recourse.

Medical Care

(dollars in millions)



Medical Care

1987

- A $75 million rescission is proposed to eliminate funding for care of higher income, non-service disabled veterans who are financially able to provide for their own medical care.

- The FY 1987 funding includes a $10 million transfer from the Department of Health and Human Services (HHS) to expand the VA outpatient drug and alcohol dependence program.

Medical Care

1988

- The FY 1988 request of $10 billion is $414 million greater than FY 1987 including the 1987 rescission.

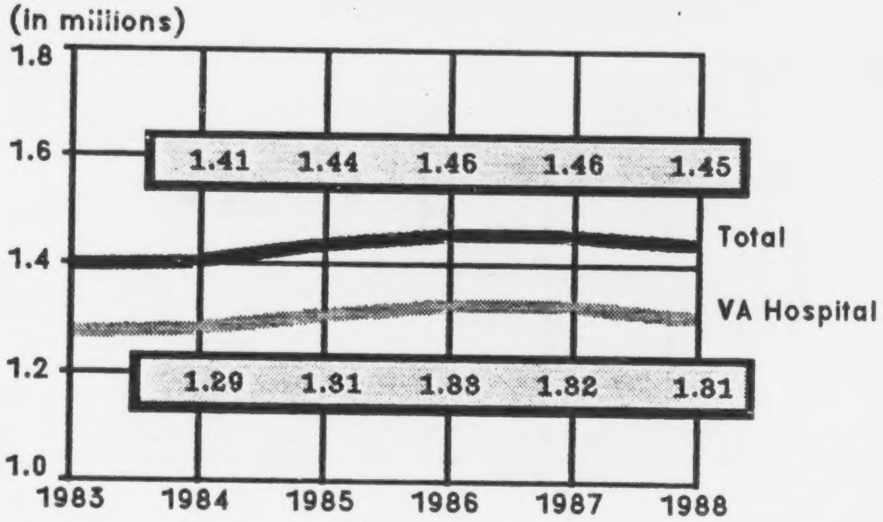
- The budget provides for activation of 282 nursing home beds which have been converted from hospital beds.

- The budget provides for treating over 1.4 million inpatients and over 20 million outpatient visits.

- The employment request of 190,330 FTEE provides an increased employment level of 1,981 FTEE for facility activations. This will provide for the care of service-connected and other categories of veterans which are exempted from a means test and veterans most financially in need.

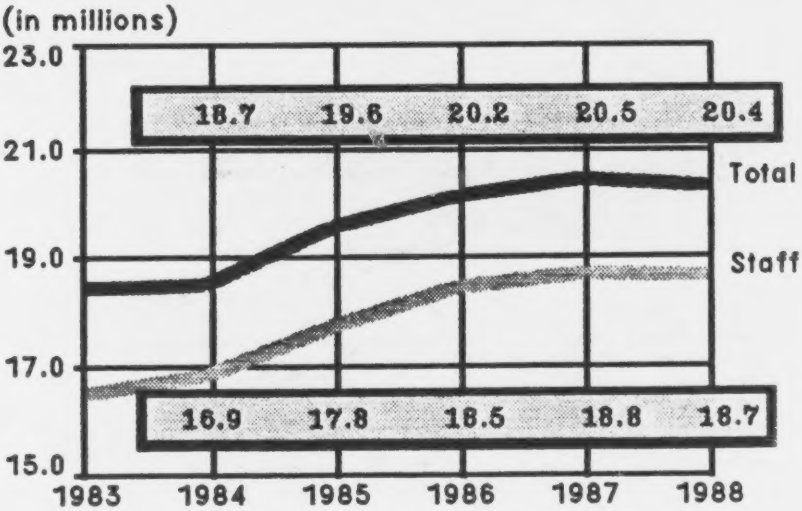
Key VA Medical Workloads

Total Inpatients Treated



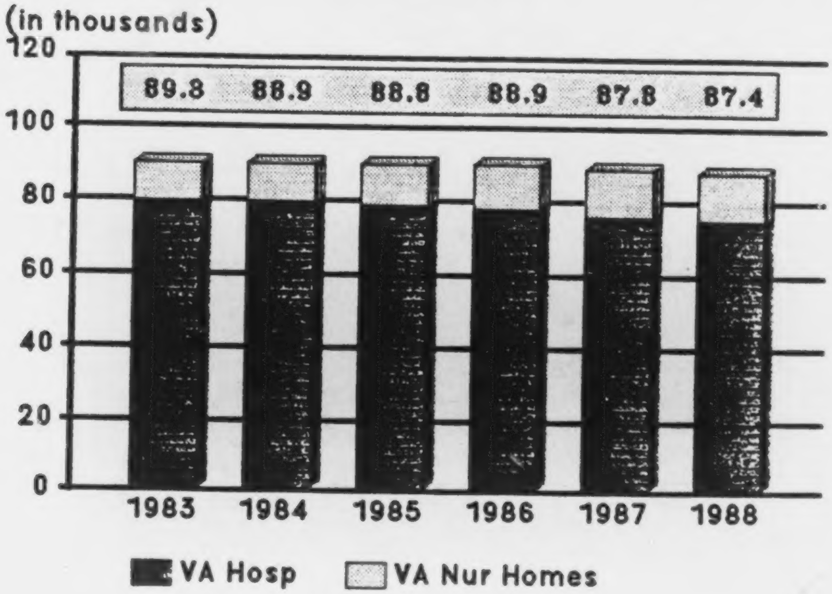
Key VA Medical Workloads

Outpatient Medical Visits



Operating Beds - Average

1983 - 1988



VA Nursing Homes

	New Beds	**Conversions**
FY 1987		
San Antonio, TX	120 *	
Alexandria, LA	120	
Loma Linda, CA	60	
Miami, FL	120	
St. Louis, MO	60	
Salt Lake City, UT	26	
Batavia, NY		25
Buffalo, NY		34
FY 1988		
Minneapolis, MN	120 *	
Bath, NY	- 43	

* New nursing homes

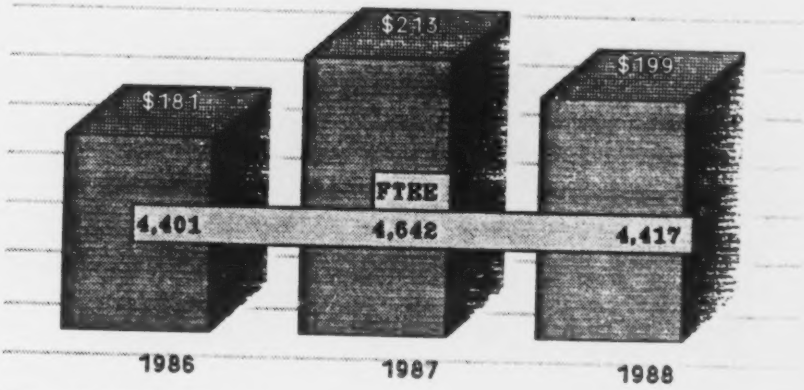
VA Nursing Homes

FY 1988 (Cont'd)	New Beds	Conversions
Lyons, NJ	150	
Northport, NY	120 *	
Butler, PA		45
Albany, NY		23
Ft. Lyon, CO		37
Miles City, MT		34
Brooklyn, NY		73
West Haven, CN		35
Bonham, TX		20
Roseburg, OR		15

* New nursing homes

Medical & Prosthetic Research

(dollars in millions)



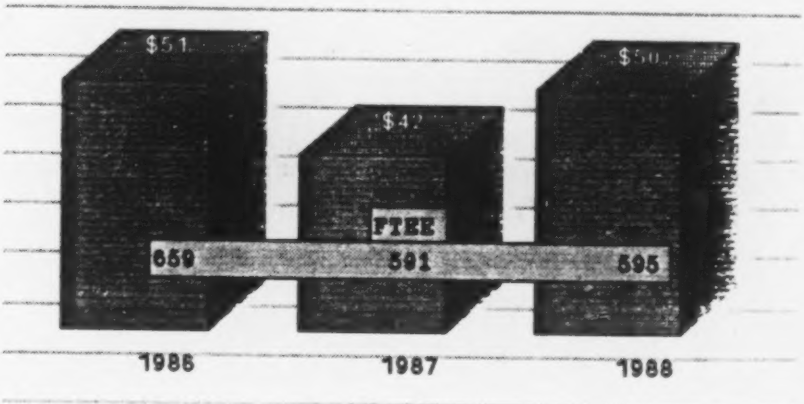
Medical & Prosthetic Research

- The 1987 request includes a $20 million appropriation transfer from DoD for a DoD/VA cooperative research program. The funding is available for two years. (Legislation is being proposed to extend the availability over four years.)

- An increase of $2.4 million is requested to support an epidemiology study of Women Vietnam Veterans.

Medical Administration and Miscellaneous Operating Expenses

(dollars in millions)

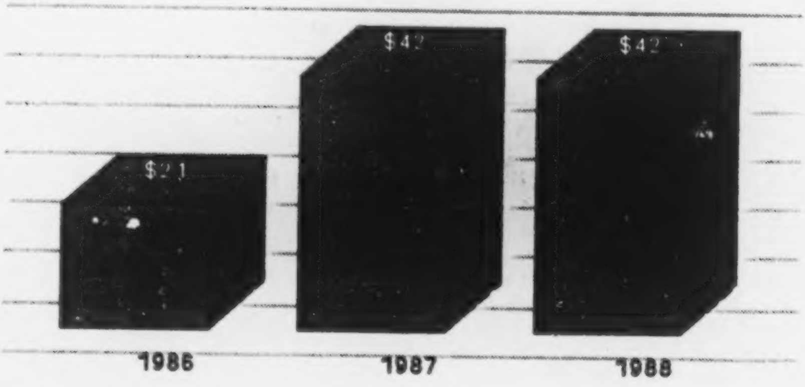


MAMOE

- The 1988 budget contains $6 million and 9 FTEE to reactivate the Health Professional Scholarship Program to support 211-one year awards and 84-two year awards to nursing and physical therapy students.
- An increase of $1 million was requested for collection of mortality/morbidity data required by P.L. 99-166.

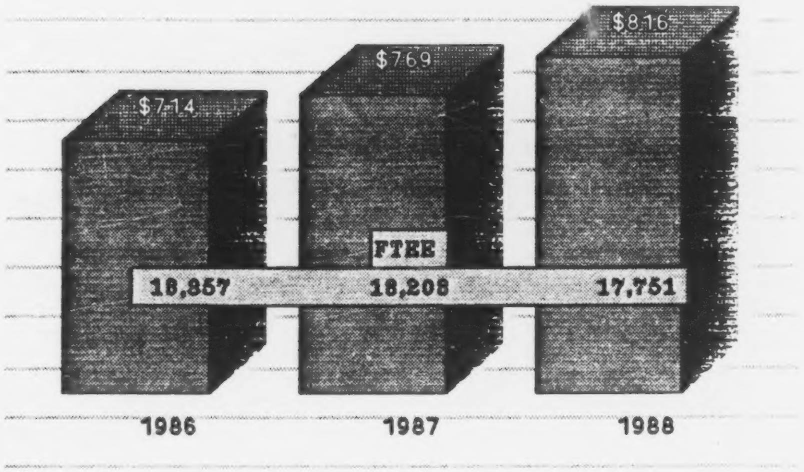
Grants for Construction of State Extended Care Facilities

(dollars in millions)



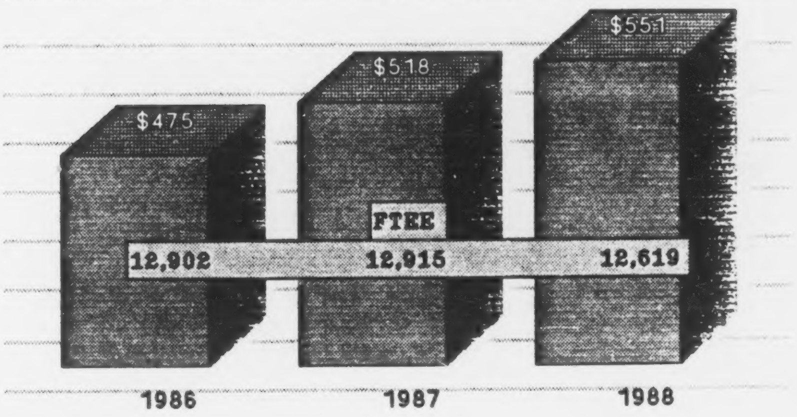
General Operating Expenses

(dollars in millions)



Department of Veterans Benefits

(dollars in millions)

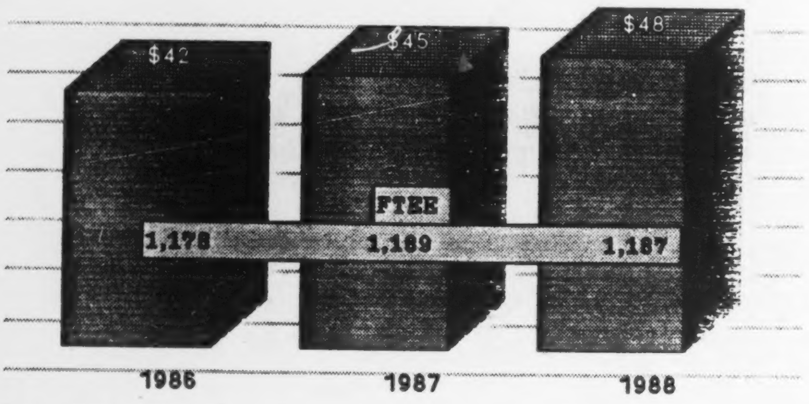


Department of Veterans Benefits

- $34.4 million is requested for the continuation of the modernization initiative which is a $150 million project over six years. The primary focus in 1988 will be the purchase of the hardware & software for the Regional Office applications, which will enhance service to veterans while making the office operations more efficient.
- $8.9 million is requested for GSA project to reduce storage space requirements for the Records Processing Center in St. Louis. This initiative is expected to have savings government-wide (not VA) of $40 million over 20 years.
- Lower workloads and miscellaneous decreases result in a net savings of $6.5 million.

Department of Memorial Affairs

(dollars in millions)



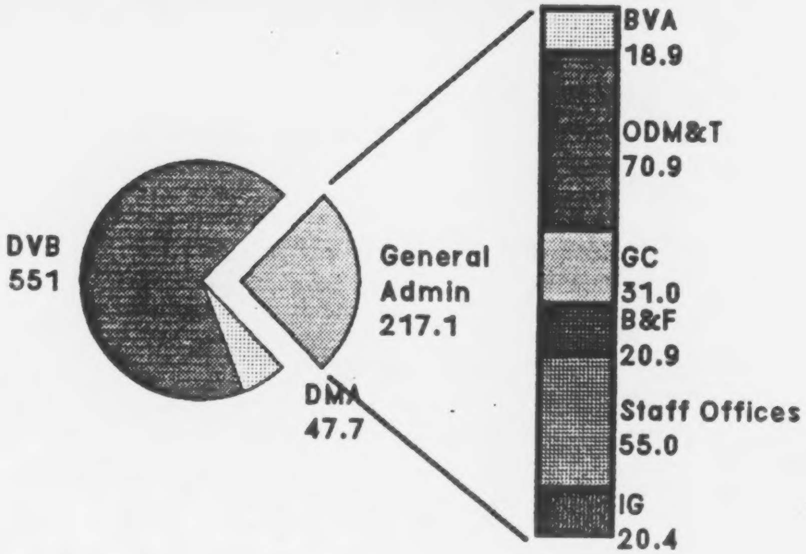
Department of Memorial Affairs

- FTEE increases are requested for workload (4 FTEE) and the opening of the Florida National Cemetery in 1988 (14 FTEE) These are offset by a reduction of 20 FTEE due to contracting out of certain cemetery operations for more efficient operations.

- Workload growth also accounts for a non-payroll increase of $1 million, including general system expansion and the Florida activation, as well as higher requirements for supplies, materials and utilities.

General Operating Expenses

1988 Budget Authority ($ in millions)



Staff Offices

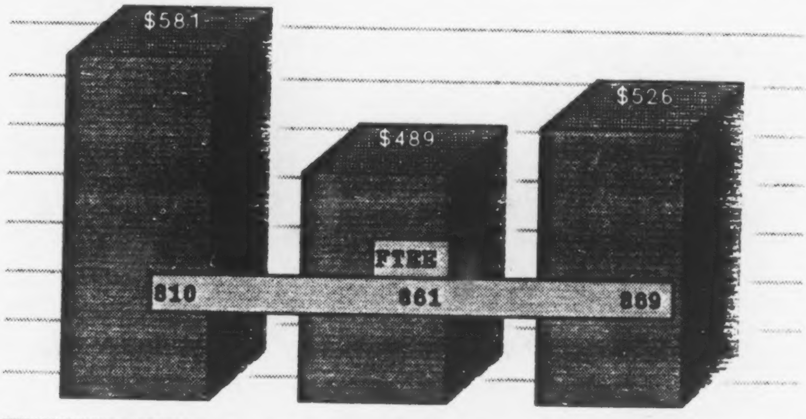
- $3.8 million is requested for ADP initiatives. Funding in ODM&T will support various agency systems, including PAID redesign, a supply system redesign, and the accounting system (CALM) upgrade.

- Savings of $1.2 million and 131 FTEE are expected due to contracting out of data processing center operations and audiovisual services.

- Improved efficiency realized by recent office automation initiatives and the elimination of non-recurring expenditures will reduce costs by $2.3 million and 24 FTEE.

Construction Program Summary

(dollars in millions)



Includes funding for Parking Garage Revolving Fund

Construction Program Summary

- This budget request provides for $525.7 million for total construction programs. Of this total, $400.6 million will fund major projects; $121 million will fund minor projects; and $4.1 million is for the parking garage fund.

- Included in these totals are:

Medical Programs:	$457.3 million
Regional Offices:	9.0 million
Cemetery Program:	18.8 million
Staff Offices:	6.2 million
Parking Garage Fund:	4.1 million
General Administration:	42.7 million
Less: FY 87 Design Fund:	-12.4 million
Total	$525.7 million

Construction Program Funding

(dollars in millions)

Replacement and Modernization	
Atlanta, GA	$ 6.8
Dayton, OH	74.1
North Chicago, IL	83.8
Palm Beach, FL	13.0
Pittsburgh (Aspinwall), PA	5.7
San Francisco, CA	6.7
Total	$190.1
Nursing Homes	
Minor Projects	$ 4.5
Total	$ 4.5

Construction Program Funding

(dollars in millions)

Domiciliaries	
Prescott, AZ	$11.1
Total	$11.1
Outpatient Improvements	
Montgomery, AL	$26.6
Minor Projects	1.5
Total	$28.1
Clinical Improvements	
Huntington, WV	$43.4
Jackson, MS	38.0
Minor Projects	14.0
Total	$95.4

Construction Program Funding

(dollars in millions)

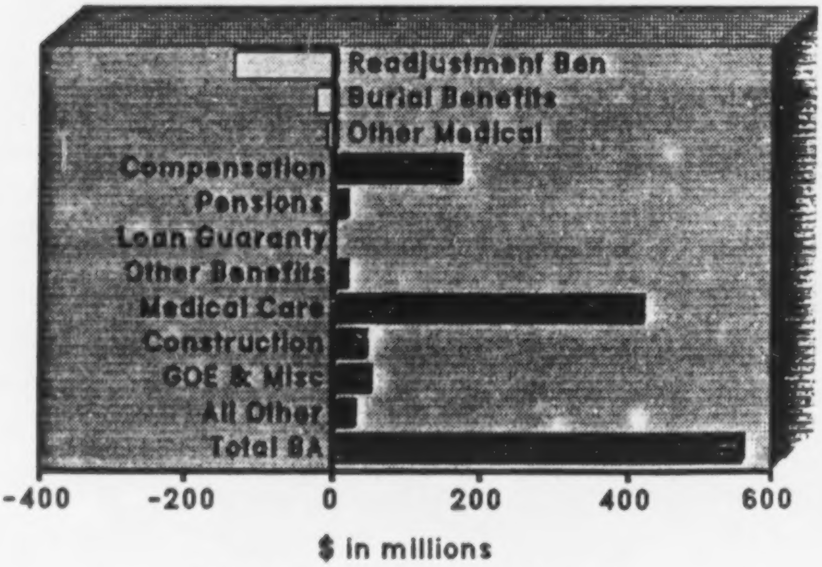
Fire & Safety	
Indianapolis, IN	$ 3.4
Livermore, CA	9.5
Waco, TX	14.5
Minor Projects	1.5
Total	$28.9
All Other	$133.2
General Administration	$ 42.7
Add, Parking Garage Revolving Fund	+ 4.1
Less, FY 1987 Design Fund	$-12.4
Total, Program Level	$525.7

1988 Budget Authority
(Includes Legislation)

(dollars in thousands)	1987	1988	Change
Benefit Programs	$15,190,520	$15,223,577	$+33,057
Medical Programs	9,851,480	10,258,722	+407,242
Construction Programs	488,708	525,694	+36,986
GOE	769,242	816,100	+46,858
All Other	727,553	751,268	+23,715
Total, BA	$27,027,503	$27,575,361	$+547,858

FY 88 Request Vs FY 87 Estimate

Total Budget Authority



Includes proposed legislation

MEDICAL MALPRACTICE CLAIMS AND LITIGATION FOR FY 1983 THROUGH 1986

The following table depicts the experience of the Veterans Administration in medical malpractice claims and litigation for the Fiscal Years 1983 through 1986. The total amount paid in Fiscal Year 1986 was approximately $33 million, down from the record $35 million paid in Fiscal Year 1985, but still well above the $16 to $17 million annual payout experienced in the early 1980's.

ADMINISTRATIVE CLAIMS

FY	Claims Files	Claims Settled	Amt. Paid in Claims Settled
83	824	181	$ 4,482,520
84	847	190	5,692,487
85	820	136	14,464,433
86	922	195	10,361,648
TOTAL	3,413	702	35,001,088

LITIGATION

FY	Filed	Dismissals	Jgt U.S.	Jgt Plaintiff	Settlements/Amt.
83	284	83	35	17/$ 2,374,656	94/$ 9,195,011
84	266	71	27	16/ 4,229,897	97/ 8,059,466
85	283	69	57	15/ 7,484,353	164/ 13,055,818
86	339	56	34	13/ 5,140,419	151/ 17,454,963
TOTAL	1,172	279	153	61/$19,229,325	506/$47,765,258

AIDS RESEARCH

The VA is engaged in the entire spectrum of research on AIDS, from basic science studies of the mechanism of AIDS virus infection, through clinical trials of drugs in the treatment of veteran patients with AIDS.

In the area of basic research, a number of VA laboratories are studying the mechanism by which AIDS virus infects cells. Dr. John Ziegler of the San Francsico VAMC is studying the molecular events, triggered by AIDS virus infection, that result in the death of essential cells of the immune system. Dr. Paul Hoffman of the Baltimore VAMC is using a mouse model of AIDS infection to understand how the virus attacks and kills nerve cells. Dr. Bernard Poiesz of the Syracuse VAMC has been investigating the mechanism by which viruses, similiar to AIDS virus, cause certain cancers of the lymphatic system in animals. This area of research is important to our understanding of why some AIDS patients develop these kinds of cancers. In other animal studies, Dr. Stephen Wright of the Salt Lake City VAMC is working on a vaccine for an AIDS related animal virus.

In the area of clinical research, Dr. Susan Zolla-Pazner of the Manhattan VAMC is investigating the impact of AIDS virus infection on the functioning of the immune system, and Dr. Michael Simberkoff, also of Manhattan, is attempting to improve therapy for the serious infections that attack AIDS victims because their immune systems malfunction.
Dr. Wallace Tourtellotte of the West Los Angeles VAMC and Dr. Peter Dowling of the East Orange VAMC are studying infection of the nervous system in patients with AIDS. A number of other VA investigators (Drs. Dobbins, Ann Arbor, and Klotman, Durham) are studying "opportunistic infections" (serious infections that attack patients with deficient immune function) in AIDS patients.

Several VA investigators are actively engaged in the development and testing of new drugs for the treatment of AIDS infection. Dr. Raymond Schinazzi of the Atlanta VAMC is designing new drugs targeted against the unique biochemical pathways of the AIDS virus. Drs. John Bilello and Paul Hoffman of the Baltimore VAMC are supported by the NIH to test new, potentially useful drugs against AIDS, in an animal virus model infection, similiar to human AIDS. And the VA is carrying out a large scale, controlled clinical trial of the efficacy of azido thymidine (AZT) treatment in patients with AIDS-related complex (ARC). This trial is supported by special AIDS research funds from the Department of Defense and is the only evaluation of AZT's ability to stop the clinical progression of infection by the AIDS virus.

DM&S Plan for Satellite Outpatient Clinics (SOC)

BACKGROUND

The VA's plan for SOCs is created through the Medical District Initiated Program Planning (MEDIPP) process. The Guidance which underlies the MEDIPP process contains a methodology for determining the need for SOCs and also for ranking proposed clinics in priority order. The methodology comes in two parts: (1) threshold criteria, and (2) ranking criteria. The SOC methodology recently has been re-evaluated, and the results of the re-evaluation are currently being reviewed for concurrence in VA Central Office. Until the revisions have been approved, proposals for new SOCs will continue to be assessed according to the criteria which currently exist.

THRESHOLD CRITERIA

Threshold criteria are the basis for consideration of a proposal. Deviations from the criteria are considered only if they are thoroughly documented when the proposal is submitted. The basic threshold criteria used in MEDIPP are:

(1) total Metropolitan Statistical Area (MSA) of 100,000 population or more;
(2) Primary Service Area (PSA) formed around MSA location;
(3) 20,000 or more outpatient visits projected;
(4) SOC site 75 miles or more from an existing VA medical facility; and
(5) Backup hospital in area for emergency support.

RANKING CRITERIA

Ranking criteria consist of objective data used by the Department as a tool to aid in determining the relative priority of SOC proposals. The rankings derived from this process represent departure points for subsequent operational and budgetary planning. Activation dates for SOCs, however, may not coincide with priority rankings because of the many operational factors which tend to increase or decrease the time required to open a clinic. The ranking criteria used in MEDIPP are:

(1) projected number of outpatient visits; and
(2) distance/remoteness. This criterion gives added weight to the proposed clinic with the greatest distance to an existing VA facility. Lesser weights are given to clinics closer to existing VA facilities.

CURRENT DM&S PLAN

The VA currently has 12 SOCs in some stage of planning. Of the 12, two have been included for lease funds in past budgets: Crown Point, IN and Ponce, PR. Because they appear in the budget, these two SOCs have the highest priorities for SOCs. Of the remaining 10 SOCs, 5 are approved at MEDIPP Level 3 which is the highest MEDIPP approval and means that a proposal is eligible for consideration in an Agency budget request. The five approved at Level 3 are: Savannah, GA, Duluth, MN/Superior, WI, Tallahassee, FL, Ocean County, NJ, and Lufkin/Tyler, TX. All 5 of the SOCs at Level 3 are under active operational planning, and their relative priorities will be determined by the administrative and logistical factors inherent in the operational process. Funding for these 5 SOCs will be included in future budget requests as dictated by the operational planning process. The last 5 SOCs are approved at MEDIPP Level 2 which means that further operational planning is needed before they can be considered for inclusion in an Agency budget request. The relative priorities for these five clinics, based on the ranking methodology, are as follows: (1) Ft. Worth, TX; (2) Lawton, OK; (3) San Jose, CA; (4) Austin, TX; and (5) Mount Vernon, MO. Attached is a description of the MEDIPP levels of approval.

A summary of all 12 SOCs follows:

Funds Provided in Agency Budget Request (alphabetically):

Crown Point, IN
Ponce, PR

Approved at MEDIPP Level 3 (alphabetically):

Duluth, MN / Superior, WI
Lufkin / Tyler, TX
Ocean County, NJ
Savannah, GA
Tallahassee, FL

Approved at MEDIPP Level 2 (in rank order based on methodology)

Ft. Worth, TX
Lawton, OK
San Jose, CA
Austin, TX
Mount Vernon, MO

One SOC Pending Approval

Huntsville, AL

DM&S will soon forward a recommendation to the Administrator for establishment of an SOC in Huntsville, AL.

Attachment

Three Levels of Medical District Initiated Program Planning (MEDIPP) Approval

Level One - Chief Medical Director and Administrator Concurrence with MEDIPP Needs Assessments

At the end of each annual MEDIPP planning cycle, the Chief Medical Director and Administrator are asked to concur in the medical district's assessments of program need for future actions, projects, and mission changes. The concurrence of the CMD and Administrator in these assessments signifies that the Districts have adequately identified and validated certain future needs for new programs or changes in existing programs. The Chief Medical Director's and Administrator's concurrence with the District program needs assessments at this point in the planning does not mean that all necessary planning for the proposed action has been accomplished, and it does not provide assurance that funds needed to support implementation of the action will be budgeted.

Level Two - Approval for Advanced MEDIPP Implementation Planning

After the Level One concurrence of the Chief Medical Director and Administrator, an action or project may require additional, detailed implementation planning (e.g. determination of a specific site for the project; detailed staffing requirements for the project). Items approved for advanced MEDIPP implementation planning will be included in an annual DM&S MEDIPP implementation plan. Implementation planning will be conducted prior to making final decisions to implement the action. The decision to implement the action is made by the Veterans Administration Department of Medicine and surgery official who has the delegated authority to do so.

Level Three - Approval of MEDIPP Actions and Initiatives for Inclusion in the Administraton's Budget Proposal

Certain MEDIPP actions cannot be implemented without the availability of additional appropriations. Therefore, these actions must be prioritized and submitted for possible inclusion in the Administration's budget proposal. Decisions as to which items are ultimately included are made through the routine, annual budget preparation process.

Note: Levels two and three do not necessarily occur in sequence. At times, implementation planning is completed prior to budget preparation. At other times, implementation planning continues or begins after the development of the budget (e.g. major construction projects).

The FY 1988 Medical care current service estimate follows:

	FTEE	BA $(000)
1987 Appropriation.....................	194,140	$ 9,411,817
HHS transfer......................	...	10,395
Payraise and FERS supplementals...	...	206,295
1987 Adjusted Base.....................	194,140	9,628,507
1988 Changes:		
Capital Invest. Adj.............	...	- 199,031
Facility activations...........	1,981	174,882
HBHC annualization.............	12	740
Meharry affiliation............	1	54
Rental & Com. Svc. transfer.....	...	3,864
Payroll increases incl. payraise & FERS annualization.	...	393,507
Inflation......................	...	178,059
1% Productivity................	- 1,911	- 58,297
HHS non-recurring transfer......	...	- 10,395
VADATS reduction................	...	- 2,502
State Home & Cal. Day Change....	...	6,449
1988 Total Current Services, unadjusted	194,223	$10,115,837
Adjustment for reduction of program level related to 1987 pay absorption pursuant to OMB circular A-11 Sec. 27.2 (b) (5)*	...	- 74,695*
1988 Adjusted Current Services.........	194,223	$10,041,142

The adjusted current services is $73,534,000 and 3,893 FTEE more than the 1988 request level and $487,635,000 and 1,483 FTEE more than the proposed 1987 level (which includes the impact of the proposed rescission).

*Absorption of payraises reduces the non-payroll spending and thereby lowers the current services base throughout the projection period.

HVAC hearing
file
2/3/87

FEB 17 1987

Honorable Paul E. Kanjorski
House of Representatives
Washington, D.C. 20515

Dear Mr. Kanjorski:

During the House Veterans Affairs Committee Hearing on February 3, 1987, you extended us the opportunity to provide additional information about the Wilkes-Barre, Pennsylvania Nursing Home Care Unit project.

I am pleased to provide for the record the attached white paper about that project. I appreciate the opportunity to provide this supplemental information.

Sincerely,

THOMAS K. TURNAGE
Administrator

cc: 101B
101B11
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VAMC Wilkes-Barre, PA
10BA2

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NURSING HOME CARE UNIT
VA MEDICAL CENTER, WILKES-BARRE, PA

Congressional Conference Report No. 99-363 directed the VA to "proceed with the design of a 60-bed Nursing Home Care Unit at Wilkes-Barre in 1986."

Accordingly, the project was included in the FY '86 Working Drawing Design Fund Request. Preliminary design of the project was completed in October 1986.

Due to system-wide priorities, the VA does not expect to begin design/construction of this project until FY '93. It was decided, therefore, that all work on the project should stop because it was not considered prudent to begin working drawing design on a project which is not expected to be constructed until at least 1993. Upon establishment of a firm funding year, a design and construction schedule can be formulated.

It is appropriate to note that a revised strategy for providing nursing home care is greater reliance on state-owned programs. In concert with that strategy we have increased the proportion of nursing home care services to be provided by state and community nursing homes. It is our belief that this market mix will facilitate meeting veterans nursing home care health care services in the most economic manner.

It is true there are a number of individuals on the Wilkes-Barre nursing home care waiting list. Priority for placement is first service connected and then non-service connected. Approximately 45 are service-connected veterans. As new service connected veterans apply for nursing home care, it continues to bump the non-service connected veteran who has a lower priority. Wilkes-Barre has approximately 60 patients placed in community nursing homes. They are currently exploring any service connected veteran who is on the waiting list and eligible for community nursing home care. They will request additional census and funding support if indicated and as needed to meet service-connected veteran needs. To date, they have been supported to meet their community home care workload needs.

Statement of Congressman Paul E. Kanjorski
House Veterans' Affairs Committee Hearing
February 3, 1987

Thank you, Mr. Chairman. I am pleased that General Turnage is able to join us here today to discuss the Veterans Administration budget for the coming fiscal year. I commend you, General Turnage, on your continued hard work at the VA.

Without going into great detail, I would like to say that I am once again quite disappointed with many of the items contained in this budget request, as well as some important projects which have been omitted from the budget. Despite this Administration's avowed commitment to the needs of America's veterans, each year's budget contains more and more cuts to programs and services which have proven vital to veterans and their families.

In particular, I am sorry to see a recission request for $75 million in VA funding which the Congress approved in the last Congress. I believe that such an request is not only unfair to many veterans, but it is in direct conflict with the intent of Congress as expressed in Public Law 99-272. I am hopeful that this committee and the Congress will soundly reject this proposal as ill-considered and untimely.

The budget also seeks to reduce staffing levels at a time when the needs of our veterans population are growing. The VA asserts that FTEE reductions can be made without compromising the quality of care, but I must tell you that I am skeptical of such claims. The VA medical system is already burdened with staffing shortfalls in many areas, so this does not seem to be the most prudent way to reduce the VA's costs.

I also have a special interest in the construction of a 60 bed addition to the Wilkes-Barre VA Hospital's Nursing Home Care Unit. Despite authorization by the Congress in both Fiscal Year 1986 and 1987, and the appropriation of design funds in Fiscal Year 1987, this budget seeks to eliminate this project. The budget before us gives no explanation or defense of this action, nor does it explain how the Veterans Administration intends to deal with the growing need for nursing home beds in the absence of this project.

Veterans have the same rights to quality health care today as they did when they were younger. As the needs of our veterans change, so must the VA change, to guarantee that their medical care is the best that is available. You can be certain that when we get to the time allotted for questions today that I will be asking about the VA's plans for older veterans' care in the region served by the Wilkes-Barre VA Medical Center.

Again, welcome General Turnage, and I look forward to both your testimony and your responses to Members' questions.

REPORT
1986 SURVEY OF HEALTH OCCUPATIONAL STAFF

PREPARED BY

OFFICE OF PERSONNEL AND LABOR RELATIONS

MARCH 27, 1987

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EXECUTIVE SUMMARY

Background

The VA operates a highly diversified medical system which employs more health care professionals than any other single organization in the Nation. Its ability to attract and retain a well-qualified staff and the cost of providing medical services are continuing concerns to Agency officials, members of the executive and legislative branches of government, veterans groups, and the public. Recently, many questions have been presented to Agency officials regarding recruitment and retention of certain health care professionals. While some Agency-wide employment data on VA occupations is routinely maintained, comprehensive information about local staffing situations is not. This survey was conducted to gather detailed statistical and narrative information to assess recruitment and retention trends in the covered occupations. However, it does not account for all factors which may affect recruitment and retention. For example, the demand for health care professionals has been acknowledged to exceed the supply in many communities. In such locales, the VA as well as other medical facilities may experience staffing difficulties, and the competition between the health care providers may be very keen. This survey does not attempt to address the impact of the supply versus demand issue outside the VA or in the occupation or community as a whole.

The occupations covered by the survey for which most recruitment and retention concerns have been reported included registered nurses, licensed practical nurses, nursing assistants, occupational therapists, pharmacists, and physical therapists. Other occupations surveyed were certified/registered respiratory therapists, ophthalmologist technicians, pulmonary function technicians, dental assistants, dental hygienists, diagnostic radiologic technicians/technologists, therapeutic radiologic technicians/technologists, nuclear medicine technicians/technologists, and echocardiograph technicians. For each covered occupation, all medical facilities, except the outpatient clinic in Manila, were asked to complete an extensive questionnaire covering areas such as staffing levels, gains and losses, salary and benefits offered in the local community, employee utilization, and recruitment techniques. (See Appendix A.)

Scope of Report

The goal of this survey is to assess the success of our medical facilities in recruiting and retaining employees in certain health care occupations. The responses provided by facilities to each question were tabulated and categorized. The data for each occupation was examined by facility, medical district and region to identify occupational trends. To reflect recruitment and retention in the covered occupations, several illustrations are presented as well as question-by-question analyses of facilities' responses to the survey. Included in the report are charts showing Vacancy Rates and the Net Gain or Loss Rates by medical districts and the Staffing Index categories by facility. The Staffing Index is a constructed measure which is based on two ratios: Vacancy Rate and Net Gain or Loss Rate. (A detailed explanation of this measure is contained in Appendix B.) Using Staffing Index values, a facility's ability to staff positions has been categorized as favorable or moderately, seriously, or severely difficult.

Conclusions

The data shows that the Agency as a whole is maintaining adequate staffing levels in all of the occupations covered. However, some facilities are having staffing difficulties. The degree of recruitment and retention difficulty varies widely between VA facilities.

The data presented by the VA facilities regarding private sector pay rates and pay practices is generally based on local officials' estimates, rather than on actual surveys of private sector facilities, hence, it could be subject to estimation error. Nevertheless, the data indicates that pay is one of several factors in facilities' inability to attract and retain certain health care professionals. Facilities may request special salary rates to address the disparities between Federal pay and local private sector pay. However, this option has not been used by VA facilities to the fullest extent possible within available resources. Most special rate requests processed in Central Office show that pay related staffing problems are most severe at the entry level. Generally, the pay differences between VA and private sector hospitals are greatest at the entry level and become less at the full-performance level. A more thorough review of the mechanism for authorizing special pay rates may be necessary to ensure that facilities are effectively using this option. Supplemental funding provided by Central Office may be necessary to support adequate special rates in some areas.

Group I

Registered nurses, licensed practical/vocational nurses, nursing assistants, occupational therapists, pharmacists, and physical therapists have been identified as Group I. These occupations were analyzed first because of expressed concerns within the Agency and by veterans groups, members of Congress, and concerned professional organizations. A preliminary report was prepared on this group of occupations in January 1987.

The findings indicate wide variances in the severity of facilities' recruitment and retention difficulties. While facilities experiencing serious difficulties in the recruitment and retention of physical therapists are scattered throughout the VA system, serious staffing problems in other occupations are concentrated in certain geographic areas. Difficulties recruiting and retaining registered nurses are concentrated in Arizona, California, Ohio and the mid-Atlantic states. The problem areas for occupational therapists include New England, the mid-Atlantic states, Florida and Ohio. Pharmacist staffing difficulties are concentrated in the mid-Atlantic states and Florida. Generally, staffing conditions are more favorable in less populous locations than in large, densely populated metropolitan areas.

The staffing index shows that the overall recruitment and retention situation for registered nurses, licensed practical nurses, occupational therapists, pharmacists and physical therapists is favorable for about half (46.7%) of the VA's medical facilities. The index also shows that 22.9% of the facilities are experiencing moderate difficulty; 21.5%, serious difficulty; and 8.9%, severe difficulty with these occupations. There are small net losses Agency-wide for occupational therapists, pharmacists, and physical therapists. In the nursing occupations, there are small Agency-wide net gains for registered nurses and licensed practical nurses and a very large net loss for nursing assistants. The nursing results may be attributed to an increased utilization of licensed practical nurses and registered nurses and a decreased utilization of nursing assistants in facilities' Nursing Service staffing plans.

For registered nurses, relocation rather than pay was the most frequent reason given for leaving VA employment. Relocation accounted for the second highest percentage of losses of licensed practical nurses, occupational therapists, pharmacists, and physical therapists. While relocation is not a phenomenon we can control, it is one which we may wish to take greater advantage of by facilitating the transfer of employees between facilities.

Generally, Federal fringe benefits were found to be competitive with those in the private sector, but many facilities reported that they were at a disadvantage because of certain pay practices, tuition assistance programs, child care facilities, and employer-paid health benefits. Facilities with severe recruitment and retention difficulties need to explore the development of employment strategies which will permit them to compete more effectively in their communities. Once again supplemental funding from Central Office may be required to meet these unique local situations.

Respondents in all regions indicated that they are utilizing employees in other occupations to provide services in occupational and/or physical therapy and pharmacy. Some also indicated that professional positions in these occupations had been vacant for lengthy periods of time. We believe that utilization of technicians in extended roles is cost effective and may be essential in many areas where it is difficult to locate adequate numbers of professionals. Central Office guidance in establishing such positions may be necessary.

The survey showed that approximately 5% of students who were trained at a VA facility accepted employment at that facility. However, this statistic does not capture (1) students who may have been employed at a VA facility other than the one in which they trained or (2) students who were not eligible for immediate employment when they completed their VA phase of training, but were or will be employed in the VA subsequent to completion of all required education and training.

Newspaper advertising was the most frequently used and the most effective means of locating candidates. It is noted that this is also less expensive than other formal recruitment techniques, such as college visits, job fairs, and professional association meetings. Private sector medical facilities were the primary source of VA hires in all occupations; recent graduates were the second most productive source.

Group II

This is a summary of the findings for other occupations included in the survey: certified/registered respiratory therapists, diagnostic radiologic technicians/technologists, therapeutic radiologic technicians/technologists, dental assistants, dental hygienists, echocardiograph technicians, nuclear medicine technicians, nuclear medicine technologists, ophthalmologist technicians, and pulmonary function technicians. These have been identified as Group II.

Diagnostic radiologic technicians/technologists, certified/registered respiratory therapists, and dental assistants are the most populous occupations in Group II, each with 1,000 or 2,000 employees. By comparison, the seven other occupations in this group represent fairly small populations (each with less than 250 employees) in the DM&S workforce. Since individual VA facilities usually have one or two employees in these occupations, only a few changes in staff can drastically skew the statistics of the group. A facility turnover rate of 100% may mean that only one person separated whereas a vacancy rate of 0% can be achieved if only one position is filled. Therefore, caution should be taken in drawing general conclusions from staffing data for these occupations.

The staffing index shows that the overall recruitment and retention situation in the various occupations is favorable in 78.3% of the facilities that responded. The index also shows that 6.1% of the facilities are experiencing moderate difficulty; 6.1%, serious difficulty; and 9.5%, severe difficulty. Agency-wide net gains are reported for respiratory therapists, dental hygienists, echocardiograph technicians, and nuclear medicine technicians. There are Agency-wide net losses for diagnostic radiologic technicians/ technologists, dental assistants, nuclear medicine technicians, and pulmonary function technicians. Gains equaled losses for therapeutic radiologic technicians/technologists and ophthalmologist technicians.

The degree of recruitment and retention difficulty varies widely between occupations, and within each occupation, between facilities. Facilities experiencing serious difficulty in the recruitment and retention of diagnostic radiologic technicians/technologists are concentrated in California and the mid-Atlantic and northeastern states. Difficulties recruiting and retaining respiratory therapists and dental assistants are concentrated in California and the northeastern states. Few facilities reported staffing difficulties for therapeutic radiologic technicians/technologists, dental hygienists, echocardiograph technicians, nuclear medicine technicians, nuclear medicine technologists, ophthalmologist technicians, and pulmonary function technicians; however, when these occupations are viewed as a group, problem situations are concentrated in California and the mid-Atlantic and northeastern states.

The survey assessed several factors, such as pay and fringe benefits programs, which contribute to facilities' abilities to recruit and retain health care personnel. The findings for these occupations closely parallel those in Group I. For example, pay, relocation, and retirement accounted for most of the losses.

ANALYSIS OF SURVEY RESPONSES BY OCCUPATION
WITH ILLUSTRATIONS SHOWING
NET GAIN OR LOSS RATES,
VACANCY RATES, AND
STAFFING INDEX VALUES

GROUP I

NURSING SERVICE

Part A. HIGHLIGHTS

o DM&S-wide gains exceeded losses by 202 for a net gain rate among registered nurses of nearly 0.7%. Facilities which reported the highest net losses are concentrated in Arizona, California, Ohio and the mid-Atlantic states. About 46% of our medical facilities are experiencing favorable recruitment and retention conditions. Moderate staffing difficulties are being experienced by about 25% of the facilities. Within medical districts there are significant variances in facilities' abilities to staff registered nurse positions.

o Most facilities (77.9%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

o Only 14% of registered nurse losses are attributed to opportunities for higher pay at the same level of responsibility.

o About 54% of the facilities reported that VA registered nurses earn salaries which are comparable to or greater than those earned by their counterparts working in local non-Federal medical facilities.

o 50% of the facilities reported that the regularly scheduled general pay increases offered by private medical facilities placed them at a disadvantage in hiring and retaining registered nurses.

o Only 13% of the registered nurses who respond to VA recruitment efforts decline employment because of salary.

o Federal fringe benefits generally are competitive with those provided by private sector facilities although in some locales, health insurance and tuition assistance benefits place the VA at a disadvantage.

o On the average, less than 5% of the nursing students trained at a VA facility are hired by the facility.

o 30% percent of the registered nurses who apply for VA employment are found unacceptable by the Agency.

o Employment practices such as rotating shift policies impact on the VA's ability to recruit and retain nurses.

o Significant numbers of registered nurses and licensed practical nurses leave their VA positions to relocate. Retirement accounts for the largest number of nursing assistant losses.

o Nearly 50% of the registered nurses and licensed practical nurses hired are recruited from private sector medical facilities.

o Less than 20% of the registered nurse and licensed practical nurse new hires are recent graduates.

Part B. Analysis of Responses

1. Nursing Service Staffing Data

The staffing index shows that 45.5% of the facilities are experiencing favorable staffing conditions for registered nurses. The range of conditions and percentages of facilities experiencing them are shown below for registered nurses and licensed practical nurses.

	FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
RN	45.5%	25.1%	24.6%	4.8%
LPN	42.1%	27.4%	21.3%	9.2%

Agency-wide losses for all categories of nursing personnel exceeded gains by 893 employees (9,342 compared to 8,449) for a net loss rate of 1.6%. The turnover rate for Nursing Service is 16.6% and the vacancy rate is under 0.8%.

The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced and for psychiatric facilities (which typically have very large primary service areas) are shown below:

	RN	LPN	NA
Less than 50,000	+2.0%	+1.0%	-6.6%
50,000 to 100,000	+1.3%	+5.4%	-11.7%
100,000 to 250,000	+0.1%	+6.0%	-8.1%
Over 250,000	+0.8%	+1.1%	-9.1%
Psychiatric Facilities	+0.7%	-2.0%	-8.2%

Most facilities (77.9%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

a. Registered Nurse Staffing Data

Agency-wide gains exceeded losses by 202 registered nurses (5,092 compared to 4,890) for a net gain rate of 0.7%. Net losses were reported by 56 facilities with the rates ranging from -0.6% to -11.8%. Those facilities with the highest net loss rates are concentrated in Arizona, California, Ohio and the mid-Atlantic states. The turnover rate for registered nurses is 16.1%. The vacancy rate is 0.2%.

The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced are shown below:

Less than 50,000	+2.0%
50,000 to 100,000	+1.3%
100,000 to 250,000	+0.1%
Over 250,000	+0.8%

Psychiatric facilities which have a broader primary service area than medical and surgical facilities reported a net gain rate of 0.7%.

b. Licensed Practical Nurse Staffing Data

Agency-wide gains exceeded losses by 297 licensed practical nurses (2,167 compared to 1,870) for a net gain rate of 3%. Facilities reporting net loss rates are concentrated in the Northwestern states, southern California, Florida, Washington, D.C., and Michigan. The turnover rate for licensed practical nurses is 18.8% and the vacancy rate is 9.3%.

Gains are shown in all areas including those of high population density. The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced and percentages are shown below:

Less than 50,000	+1.0%
50,000 to 100,000	+5.4%
100,000 to 250,000	+6.0%
Over 250,000	+1.1%

Psychiatric facilities which have a broader primary service area than medical and surgical facilities reported a net loss rate of 2%.

c. Nursing Assistant Staffing Data

Agency-wide losses exceeded gains by 1,392 nursing assistants (2,582 compared to 1,190) for a net loss rate of 8.7%. No medical districts reported net gains in this occupation. The turnover rate for nursing assistants is 16.3%. The vacancy rate indicates that the actual number of nursing assistants exceeds the authorized staffing level by 4%.

Losses are significant in all areas of population density. The net gain (+) or loss (-) rates for medical and surgical facilities are categorized by size of veteran population serviced as shown below:

Less than 50,000	-6.6%
50,000 to 100,000	-11.7%
100,000 to 250,000	-8.1%
Over 250,000	-9.1%

Psychiatric facilities which have a broader primary service area than medical and surgical facilities reported a net loss rate of 8.2%.

2. Reasons for Losses

a. RNs, LPNs, & Nursing Assistants

Almost 13% of nursing losses were attributed to opportunities for higher pay at the same level of responsibility. Detailed reasons for losses are as follows:

Relocation	13.3%
Higher pay at same level of responsibility	12.9%

Retirement	11.2%
Workload	7.8%
Family reasons	6.6%
Educational reasons	5.7%
Involuntary separation	5.5%
Different type of patient care environment	4.1%
Private practice	3.7%
Changes of job description	3.6%
Higher pay at a higher level of responsibility	3.2%
Same pay, but better fringe benefits	1.6%
Higher-level position without higher pay	0.7%
Changes occurring in Federal employment, e.g., retirement coverage, benefits, etc.	0.3%
Other	19.8%

b. Registered Nurses

Almost 15% of registered nurse losses were attributed to opportunities for higher pay at the same level of responsibility. Detailed reasons for other losses are as follows:

Relocation	15.5%
Higher pay at same level of responsibility	14.6%
Workload	10.0%
Retirement	9.0%
Family reasons	6.6%
Educational reasons	4.9%
Different type of patient care environment	4.8%
Private practice	4.0%
Changes of job description	3.1%
Higher pay at a higher level of responsibility	2.9%
Involuntary separation	2.6%
Same pay, but better fringe benefits	2.1%
Higher-level position without higher pay	1.0%
Changes occurring in Federal employment, e.g., retirement coverage, benefits, etc.	0.4%
Other	18.5%

c. Licensed Practical Nurses

Higher pay at the same level of responsibility accounted for 14.6% of licensed practical nurse losses. As with registered nurses, a significant number of losses occurred because the employees relocated. Detailed reasons for other losses are as follows:

Higher pay at same level of responsibility	14.6%
Relocation	12.6%
Educational reasons	7.9%
Family reasons	7.5%

Workload	6.6%
Involuntary separation	6.4%
Retirement	5.2%
Private practice	3.8%
Different type of patient care environment	3.7%
Changes of job description	3.4%
Higher pay at a higher level of responsibility	3.0%
Same pay, but better fringe benefits	1.2%
Higher-level position without higher pay	0.7%
Changes occurring in Federal employment, e.g., retirement coverage, benefits, etc.	0.1%
Other	23.3%

d. Nursing Assistants

Retirement (23.9%) accounted for the greatest percentage of losses in this career field. Detailed reasons for losses are as follows:

Retirement	23.9%
Involuntary separation	12.0%
Relocation	8.3%
Higher pay at the same level of responsibility	6.8%
Family reasons	5.6%
Educational reasons	5.3%
Changes of job description	5.2%
Higher pay at a higher level of responsibility	3.9%
Workload	3.3%
Different type of patient care environment	2.6%
Private practice	2.6%
Same pay, but better fringe benefits	0.7%
Higher-level position without higher pay	0.3%
Changes occurring in Federal employment, e.g., retirement coverage, benefits, etc.	0.2%
Other	19.3%

3. Sources of Gains

The sources of gains and percentages are as follows:

a. RNs, LPNs, and Nursing Assistants

Private sector medical facility	47.1%
Recent graduate	16.1%
Other VA facility	11.1%
Unemployment	9.8%
Non-medical employment	4.3%
Other medical related employment (private practice, consultant, etc.)	3.1%
Non-VA Federal medical facility	2.0%
VA scholarship recipient	1.9%
Military service	1.4%
Other	3.2%

b. Registered Nurses

Private sector medical facility	49.2%
Recent graduate	18.4%
Other VA facility	12.9%
Unemployment	6.7%
VA scholarship recipient	3.1%
Other medical related employment (private practice, consultant, etc.)	2.8%
Non-VA Federal medical facility	2.2%
Military service	1.3%
Non-medical employment	0.8%
Other	2.6%

c. Licensed Practical Nurses

Private sector medical facility	49.2%
Recent graduate	18.7%
Unemployment	10.2%
Other VA facility	7.4%
Other medical related employment (private practice, consultant, etc.)	4.5%
Non-medical employment	2.7%
Non-VA Federal medical facility	2.1%
Military service	1.0%
Other	4.2%

d. Nursing Assistants

Private sector medical facility	33.5%
Non-medical employment	23.1%
Unemployment	22.6%
Other VA facility	10.4%
Military service	2.5%
Other medical related employment (private practice, consultant, etc.)	1.7%
Non-VA Federal medical facility	0.8%
Recent graduate	0.8%
VA scholarship recipient	0.1%
Other	4.5%

4. Private Sector Pay Comparison

More than half (about 54%) of the respondents stated that VA registered nurses receive salaries which are comparable to or greater than those earned by their counterparts in local non-Federal medical facilities.

Pay differential categories and percentages are as follows:

- Much more ($4,000 per annum or more) at other facilities	16.3%
- More (up to $4,000 per annum more) at other facilities	30.0%
- Comparable	40.0%
- Less (up to $4,000 less) at other facilities	11.2%
- Much less ($4,000 per annum or more) at other facilities	2.5%

5. Pay Practices at Other Local Medical Facilities

Many VA facilities (50%) reported that regularly scheduled general pay increases at other medical facilities in their areas placed them at a disadvantage in hiring and retaining registered nurses. The pay practices cited and percentages are as follows:

Regular Pay Increases	50.0%
Weekend Premium Pay	41.5%
Overtime	16.9%
Holiday Shift	14.6%
Other	65.9%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities for registered nurses. However, facilities reported disadvantages on tuition assistance (77.2%) and health care (65%). (Some medical districts reported 100% on both of these factors.)

Facilities reported a disadvantage on day care for children (52.5%). The percentage for day care for nursing service is much higher than those reported for other occupations. Also reported as disadvantages were retirement programs (28.6%), incentive awards (23.6%), annual leave (7.4%) and sick leave (6.7%). Miscellaneous reasons were cited 56.8% of the time.

7. Necessity for Alternative Methods of Coverage

Almost 45% of facilities reported that they needed alternative methods of coverage, e.g., additional shifts and contracting out, in their nursing services. Every region reported the use of alternative methods and, with the exception of Northeastern Region, used non-nursing occupations to provide coverage. The Mid-Atlantic Region experienced the greatest need for providing alternative coverage, while the Western Region had the largest percentage of non-nursing personnel providing that coverage.

Regions and percentages are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	41.7%	0.0%
Mid-Atlantic	60.7%	3.6%
Southeastern	52.4%	4.8%
Great Lakes	40.9%	9.1%
Mid-Western	33.3%	3.7%
Western	39.1%	13.0%
Southwestern	45.5%	4.5%

8. Educational Institution Affiliations

Over 93% of the VA's medical facilities are affiliated with schools of nursing and, on average, over 23,550 registered nurses were trained annually in fiscal years 1984-86. The average number of students who accepted employment at the facilities where they were trained in those years was 1,073. The ratio of hires to trainees in the medical districts ranged from less than 1% to 9.1%.

9. Recruitment Techniques and Their Effectiveness

Newspaper advertising was the most frequently used technique for recruiting registered nurses with 134 of the facilities indicating that they had used advertising at least once and 87 facilities reported using advertising 4 or more times. College visits and referrals, i.e., local contacts, other VAMCs and the toll-free referral service in VACO, accounted for other productive recruitment techniques. Recruitment techniques and responses are as follows:

	Facilities Using 1-3 Times	Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Newspaper Ads	47	87	134	132
College Visits	72	61	133	118
Referrals	30	88	118	115
Prof. Meetings	47	41	88	68
Pamphlets	13	82	95	62
Job Fairs	68	27	95	52
Prof. Associations	45	41	86	65
Health Prof. Programs	49	22	71	56
Prof. Journals	39	5	44	30

10. Special Pay Rates

Over 64% of the facilities responded that they have considered requesting special pay rates for registered nurses. At least one facility in every medical district and all facilities in Georgia, South Carolina, Michigan, and Illinois reported that they have considered requesting special pay rates.

Of the 75 facilities responding to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund the additional cost?", 8 indicated that the decision was completely affected by the requirement; 8 said the decision was parti-affected; and 59 reported the decision was not affected.

Of the facilities with special rates in effect for registered nurses, 84 assessed their helpfulness as follows:

Helpful in resolving staffing problems	24
Partially helpful	43
Have not been helpful	17

As of October 1, 1986, 89 facilities were authorized special salary rates for registered nurses and 2 requests were pending Central Office approval. Authorizations for licensed practical nurses were in effect at 28 facilities and 2 new requests were pending consideration in Central Office.

11. Applicant Responses

Facilities hired 37% of available registered nurse applicants. Five districts were able to hire 50% or more of applicants, while only two hired 20% or less. Facilities reported that 30% of the applicants were not selected for failure to meet qualification requirements and for miscellaneous reasons, including suitability and previous work records.

Of the 33% of the applicants who declined employment, the reasons and percentages are as follows:

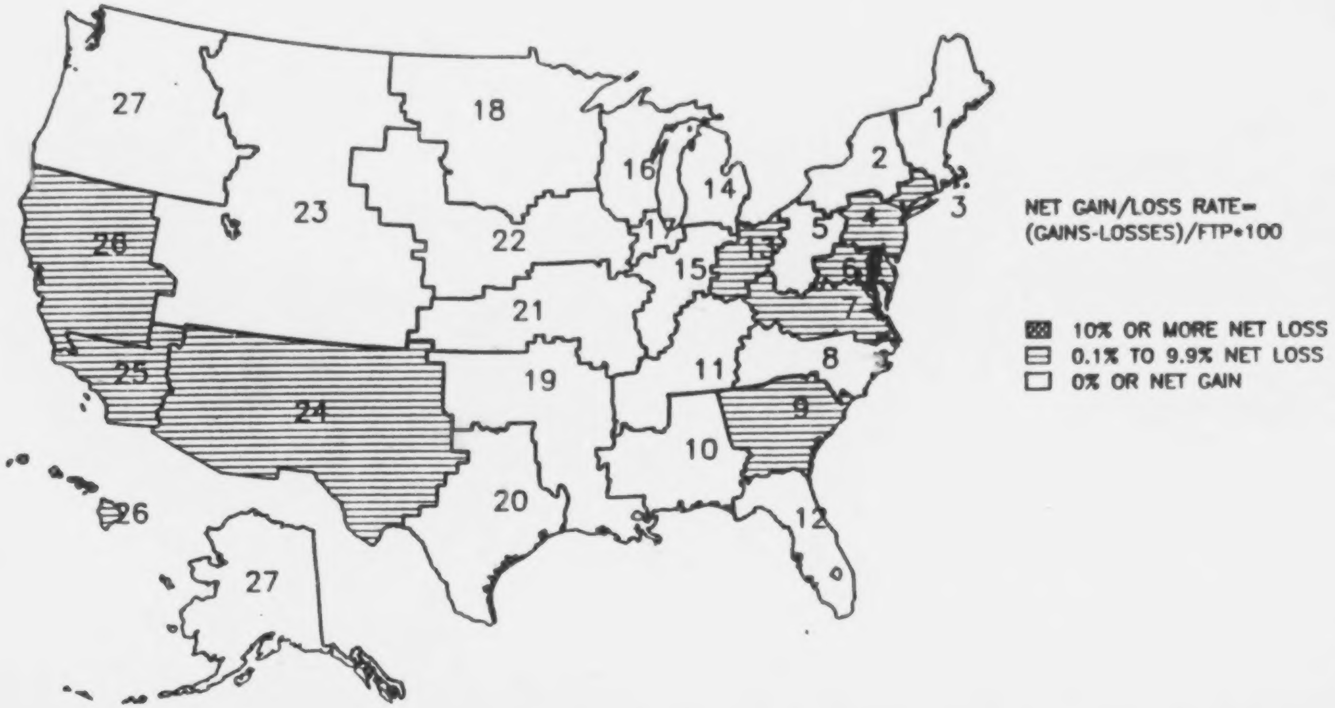
Salary	39.4%
Job Factors	24.2%
Working Conditions	9.1%
Other	27.3%

12. Comments

Additional comments to the survey were provided by 59 facilities (35.1%). Of these, 27 (45.7%) cited issues such as staff/patient ratios, rotating shift policies, workload, and stress among nursing staff. In addition, 25 (42.4%) said that salary and fringe benefit programs were significant causes of recruitment and retention difficulties. Most of these facilities indicated that they were at particular disadvantage in offering competitive starting salaries to new graduates and applicants with one or two years of experience. Additionally, they were unable to offer additional salary flexibilities available at private hospitals, including "sign-up" bonuses, regular cost-of-living increases, and greater promotion opportunities. They stated that fringe benefit programs at non-Federal medical centers offer such incentives as tuition assistance for continuing education, discounts on medical treatment at the facility, child care, and discounts on pharmacy and cafeteria purchases.

Additionally, six stations commented that they were experiencing a shortage of nursing applicants and that they have difficulty in recruiting for specialty categories. They also reported a decrease in the quality of applicants.

NET GAIN/LOSS RATE
BY MEDICAL DISTRICT FOR RNS
As of October 1, 1986


NET GAIN/LOSS RATE=
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▩ 10% OR MORE NET LOSS
▤ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN
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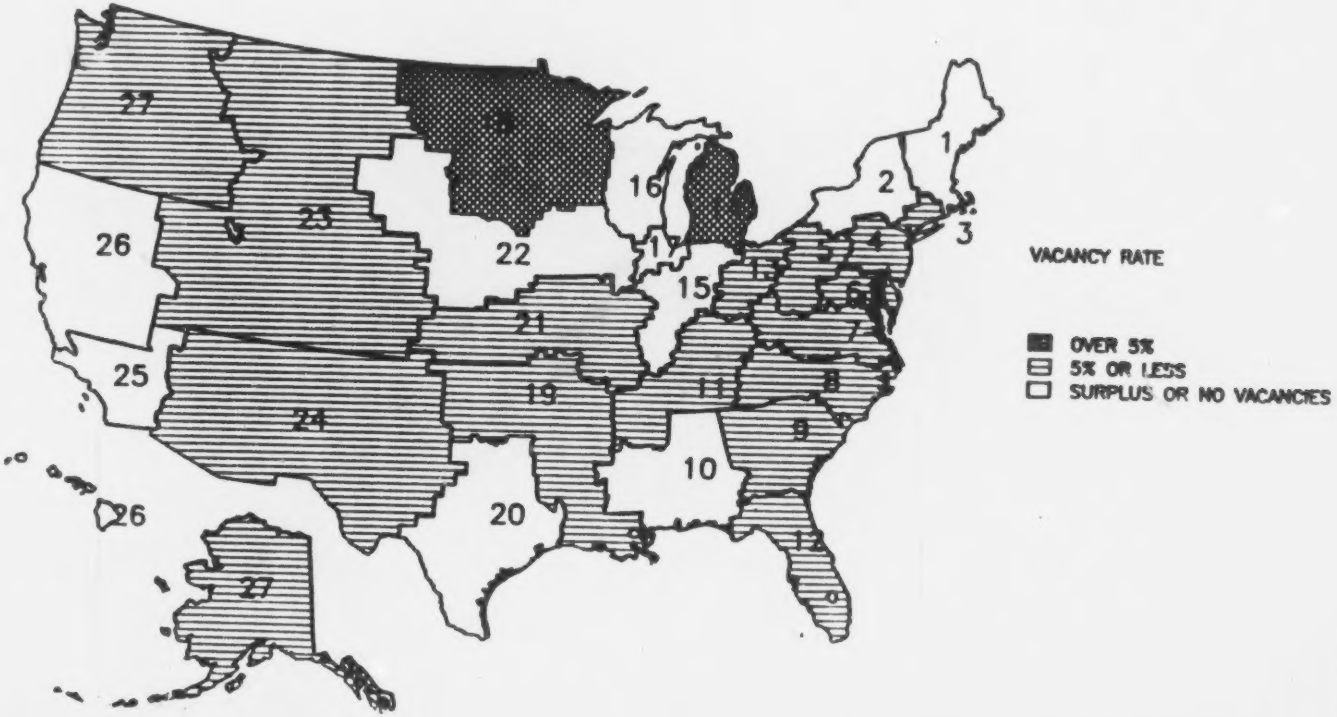
Figure 1

VACANCY RATE
BY MEDICAL DISTRICT FOR RNS
As of October 1, 1986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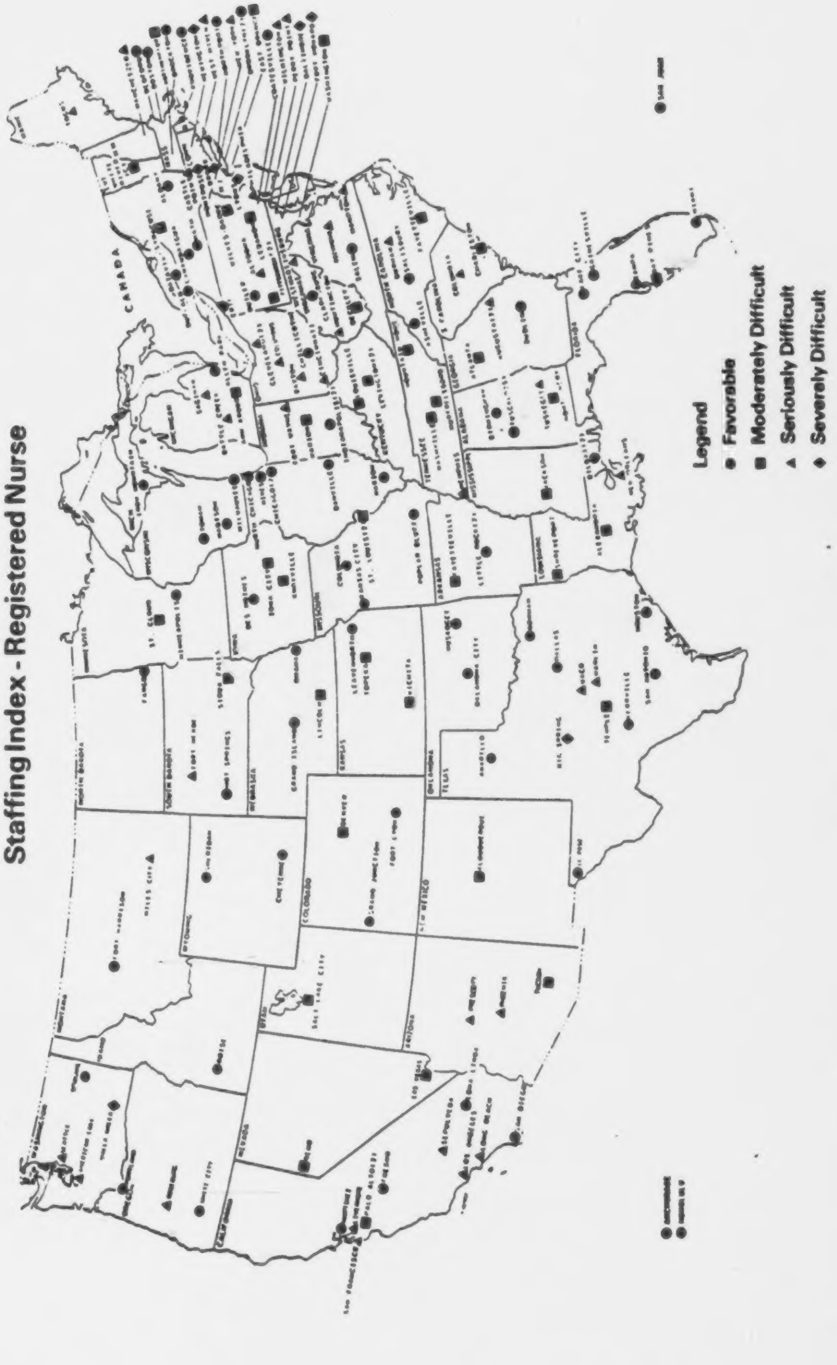
VACANCY RATE
OVER 5%
5% OR LESS
SURPLUS OR NO VACANCIES

Figure 2

Figure 3

Veterans Administration Medical Center Facilities

Staffing Index - Registered Nurse


CANADA
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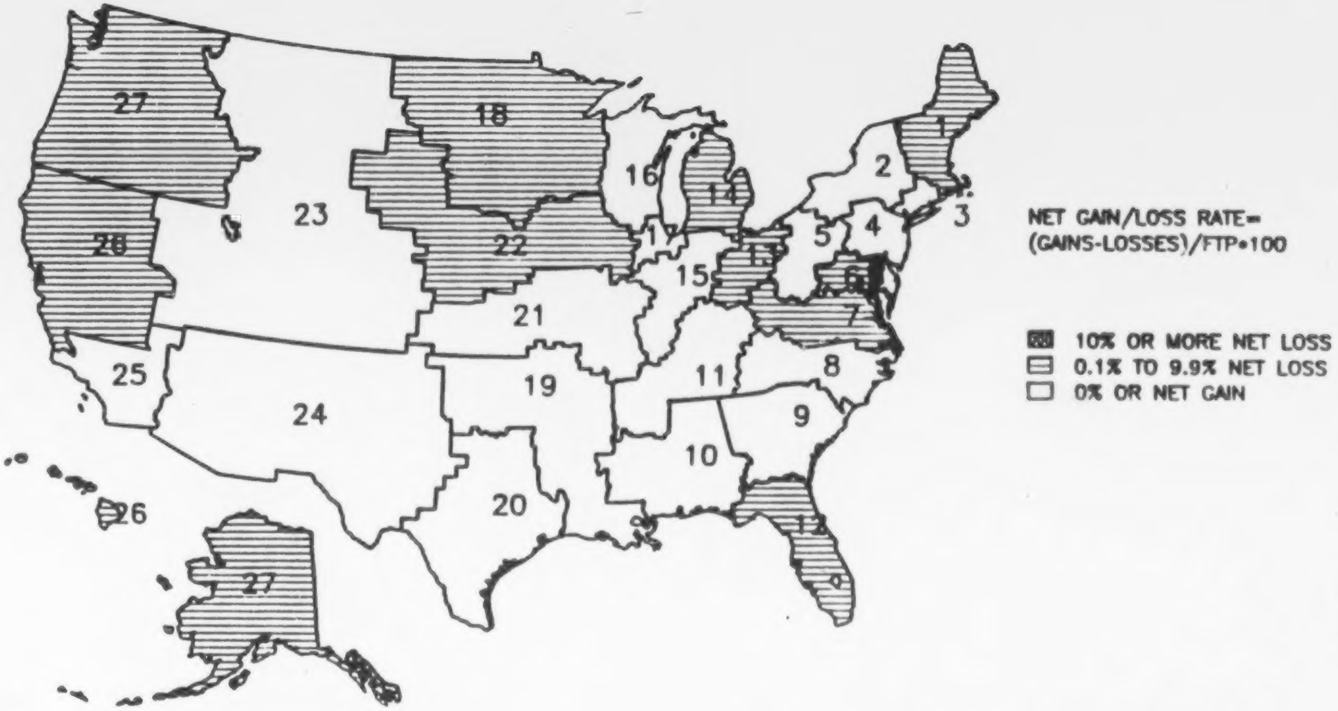
● Favorable
■ Moderately Difficult
▲ Seriously Difficult
◆ Severely Difficult

NET GAIN/LOSS RATE
BY MEDICAL DISTRICT FOR LPNS
As of October 1, 1986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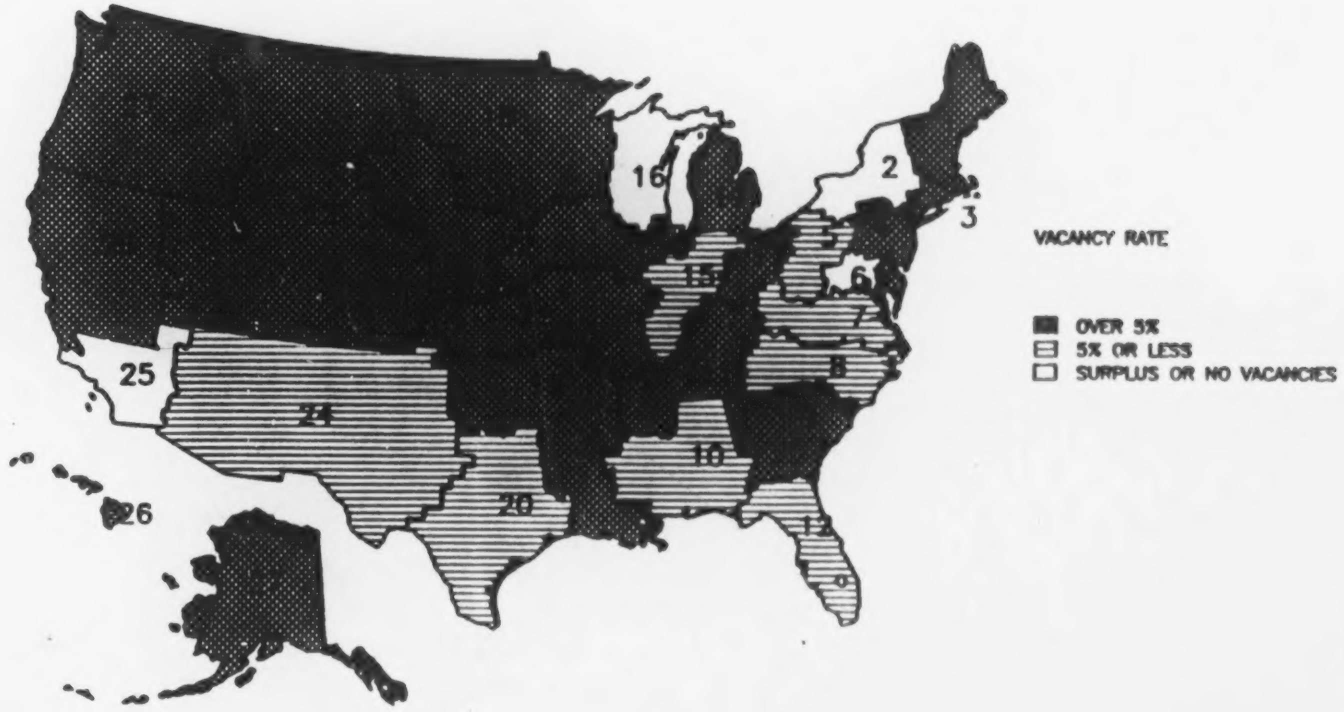
NET GAIN/LOSS RATE=
(GAINS-LOSSES)/FTP•100
▩ 10% OR MORE NET LOSS
▤ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN

Figure 4

VACANCY RATE
BY MEDICAL DISTRICT FOR LPNS
As of October 1, 1986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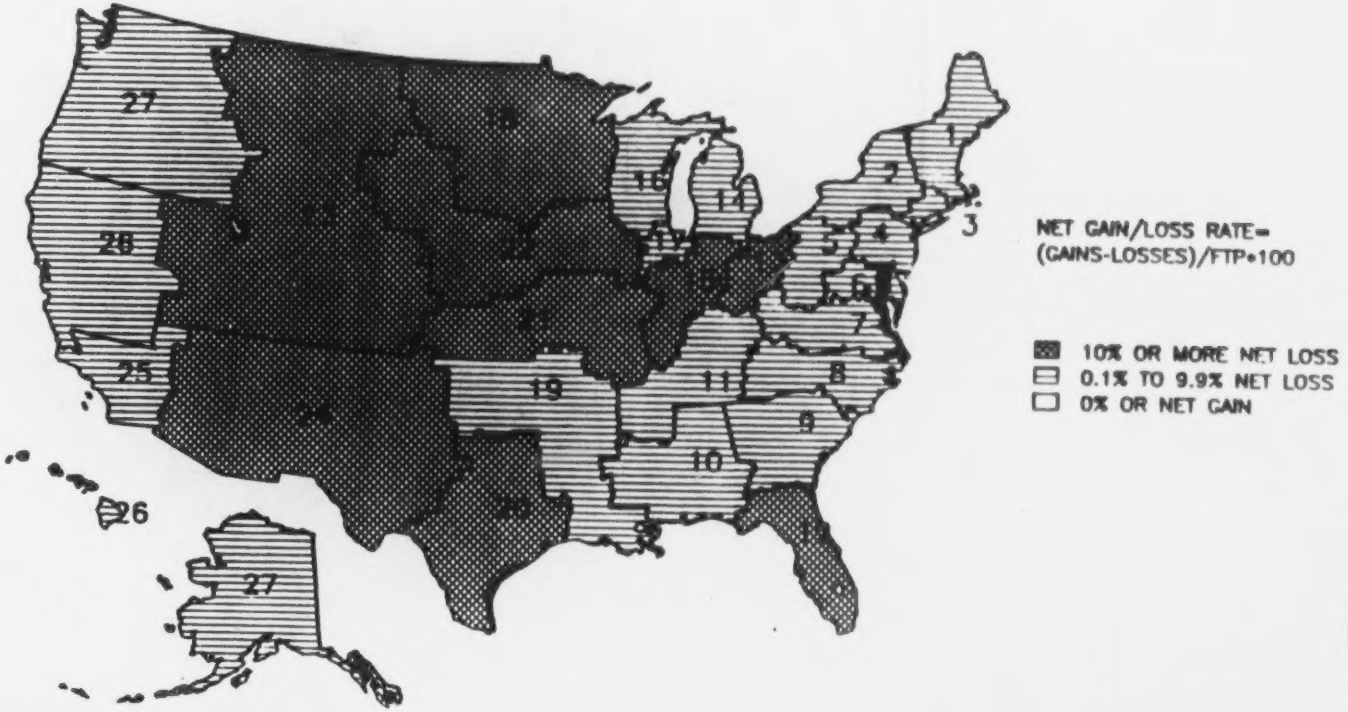
VACANCY RATE
■ OVER 5%
▤ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 5

NET GAIN/LOSS RATE BY MEDICAL DISTRICT
FOR NURSING ASSISTANTS
As of October 1, 1986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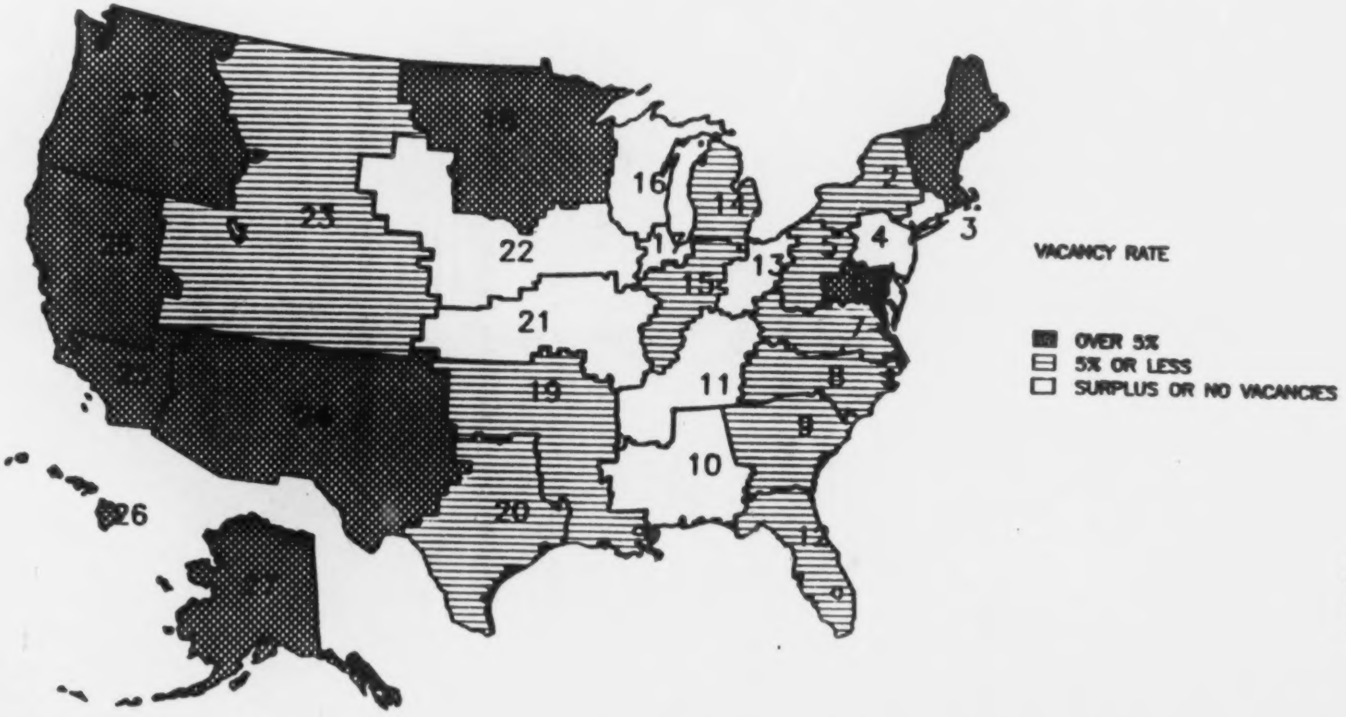
NET GAIN/LOSS RATE=
(GAINS-LOSSES)/FTP•100
▩ 10% OR MORE NET LOSS
▤ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN

Figure 6

VACANCY RATE BY MEDICAL DISTRICT
FOR NURSING ASSISTANTS
As of October 1, 1986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VACANCY RATE
OVER 5%
5% OR LESS
SURPLUS OR NO VACANCIES

Figure 7

OCCUPATIONAL THERAPIST

Part A. HIGHLIGHTS

o DM&S-wide losses exceeded gains by 28 for a net loss rate of almost 5%. Medical districts which reported greatest losses are primarily concentrated in New England, the mid-Atlantic states, Florida, and Ohio. Only 43 medical facilities (26%) reported net loss rates. About 43% of VA medical facilities are experiencing recruitment and retention problems. Moderate staffing difficulties are being experienced by about 11% of the facilities. Within a medical district or city, there are variances in facilities' ability to staff occupational therapist positions.

o Most facilities (85%) responded that sufficient funding and ceiling were available to achieve authorized staffing levels.

o Almost 60% of the occupational therapist losses are attributed to reasons other than pay.

o More than 37% of the facilities reported that VA occupational therapists earn salaries which are comparable to or greater than those earned by their counterparts working in local non-Federal medical facilities.

o 50% of the facilities reported that the regularly scheduled general pay increases offered by private medical facilities placed them at a disadvantage in hiring and retaining occupational therapists.

o 52% of those who decline VA employment do so because of salary.

o Federal fringe benefits generally are competitive with those provided by private sector facilities although in some locales, health insurance and tuition assistance benefits place the VA at a disadvantage.

o On the average, less than 5% of the occupational therapy students trained at a VA facility are hired by the facility.

o 19% of those who apply for VA employment are found unacceptable by the Agency.

OCCUPATIONAL THERAPISTS

Part B. Analysis of Responses

1. Staffing Data

The staffing index shows that 57.1% of the facilities are experiencing favorable recruitment and retention conditions for occupational therapists. The range of conditions and percentages of facilities experiencing them are shown below:

FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
57.1%	10.7%	18.8%	13.4%

Agency-wide losses exceeded gains by 28 occupational therapists (147 compared to 119) for a net loss rate of almost 5%. Medical districts experiencing net losses were scattered throughout the VA system. Medical districts in the Northwest, Florida, and Ohio reported net loss rates of 10% or higher. The turnover rate for occupational therapists is 23%. The vacancy rate is 9.2%.

Losses are generally concentrated in areas of high population density. The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced and percentages are shown below:

Less than 50,000	+18.2%
50,000 to 100,000	+1.8%
100,000 to 250,000	+2.3%
Over 250,000	-9.5%

Psychiatric facilities which have a broader primary service area than medical and surgical facilities reported a net loss rate of almost 8%.

Most facilities (85%) responded that sufficient funding and ceiling were available to achieve authorized staffing levels if candidates were available.

2. Reasons for Losses

Nearly 34% of occupational therapist losses were attributed to opportunities for higher pay with the same level of responsibility. Detailed reasons for losses are as follows:

Higher pay at same level of responsibility	33.8%
Relocation	13.4%
Different type of patient care environment	7.9%
Family reasons	7.4%
Higher pay, higher level of responsibility	6.9%
Private practice	5.6%
Retirement	5.6%
Educational reasons	5.1%
Same pay, but better fringe benefits	2.3%
Changes of job description	0.9%

Higher-level position without higher pay	0.5%
Involuntary separation	0.5%
Changes occurring in Federal employment, e.g., retirement coverage, benefits, etc.	0.0%
Other	10.2%

3. Sources of Gains

The sources of gains and percentages are as follows:

Private sector medical facility	35.8%
Recent graduate	34.1%
Other VA facility	8.9%
Other medical related employment (private practice, consultant, etc.)	8.1%
Unemployment	3.4%
Non-medical employment	2.4%
Non-VA Federal medical facility	2.4%
Military service	0.0%
Other	4.9%

4. Private Sector Pay Comparison

Nearly 63% of the respondents stated that occupational therapists working in local non-Federal medical facilities receive salaries which are higher than their VA counterparts performing comparable work.

Pay differential categories and percentages are as follows:

- Much more ($4,000 per annum or more) at other facilities	20.9%
- More (up to $4,000 per annum more) at other facilities	41.9%
- Comparable	29.5%
- Less (up to $4,000 less) at other facilities	4.6%
- Much less ($4,000 per annum or more) at other facilities	3.1%

5. Pay Practices at Other Local Medical Facilities

Exactly 50% of VA facilities reported that pay practices at other medical facilities placed them at a disadvantage in hiring and retaining occupational therapists. The reasons cited and percentages are as follows:

Regular Pay Increases	50.0%
Overtime	13.0%
On-Call	8.9%
Weekend Premium Pay	7.4%
Holiday Shift	4.9%
Other	30.4%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities for occupational therapists. However, facilities reported disadvantages on tuition assistance (63.5%) and health insurance (54.3%). (One medical district reported 100% on both of these factors; several medical districts reported 100% on one of these factors.)

Additionally, facilities reported that day care for children (31.5%), retirement programs (22.2%), incentive awards (17.3%), annual leave (15.1%), and sick leave (8.7%) put them at a disadvantage with non-Federal medical facilities. Respondents cited miscellaneous reasons 29.7% of the time.

Survey results indicate that fringe benefits at VA facilities in the Southwestern Region were more comparable to non-Federal medical facilities than any other region.

7. Necessity for Alternative Methods of Coverage

Almost 8.4% of facilities reported that they needed alternative methods of coverage, e.g., additional shifts and contracting out. All regions, except Southeastern Region, reported the use of alternative methods and the use of other occupations to provide coverage.

The Mid-Atlantic Region experienced the greatest need for using alternative methods of coverage, while the Great Lakes Region had the largest percentage of other occupations providing that coverage. Regions and percentages are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	0.0	17.4
Mid-Atlantic	26.1	20.0
Southeastern	0.0	0.0
Great Lakes	5.3	26.3
Mid-Western	4.8	17.4
Western	15.8	5.3
Southwestern	5.6	5.3

8. Educational Institution Affiliations

Over 59% of the VA's medical facilities are affiliated with schools of occupational therapy and, on average, over 640 students were trained annually in fiscal years 1984-86. The average number of students who accepted employment at the facilities where they were trained in fiscal years 1984-86 was 27. While the ratio of hires to trainees in the medical districts ranged from 0% to 33.3%, high ratios generally represented low actual hires. For example, the highest rate was in a southwestern medical district which hired 1 of their 3 students; and 12 districts trained 154 students and hired none.

9. Recruitment Techniques and Their Effectiveness

Newspaper advertising was the most frequently used technique with 57 of the facilities indicating that they had used advertising 1 to 3 times and 12 facilities reported using advertising 4 or more times. Advertisements resulted in the receipt of applications, by 27 facilities, more than any other single source. Additional recruitment techniques reported were the use of professional journals and professional association contacts. Almost 54% of the occupational therapist applications came from the Special Examining Unit in Richmond, Virginia. Recruitment techniques and responses are as follows:

	Facilities Using 1-3 Times	Facilities Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Newspaper Ads	45	12	57	27
Prof. Journals	37	8	45	19
Prof. Associations	39	10	49	17
Prof. Meetings	35	8	43	14
College Visits	27	3	30	7
Pamphlets	14	5	19	4
Job Fairs	27	1	28	4

10. Special Pay Rates

Almost 24% of the facilities that responded to this question said that they have considered requesting special pay rates. Facilities in upstate New York, North Carolina, Mississippi, Alabama, Texas, New Mexico, Arizona, and southern California reported considering special rates.

Of the 99 facilities responding to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund the additional cost?", 4 indicated that the decision was completely affected by the requirement; 6 said the decision was partly affected; and 89 reported the decision was not affected by the requirement.

The helpfulness of special pay rates in resolving staffing problems was assessed by 5 facilities with authorizations in effect. The responses follow:

Helpful	1
Partially helpful	2
Not helpful	2

As of October 1, 1986, only 6 facilities were authorized special salary rates for occupational therapists, and there were no requests for increases pending consideration in Central Office. It appears that facilities could make better use of special salary rates to compete with non-Federal medical centers, when facility funding permits.

11. Applicant Responses

Facilities hired 29% of available applicants. Seven districts were able to hire 50% or more applicants, while 6 districts hired 20% or less. Facilities reported that 19% of the applicants were not selected for miscellaneous reasons, including suitability and previous work records.

More than half (52%) of the applicants declined employment. The reasons and percentages of those who declined offers follow:

Salary	56.5%
Job Factors	7.6%
Recruitment Delays	7.6%
Working Conditions	1.9%
Other	26.4%

12. Comments

Additional comments to the survey were provided by 42 facilities (25%). Of these, 32 (76.1%) indicated that salary and fringe benefit programs were primarily responsible for recruitment and retention difficulties; 10 facilities (23.8%), most of which are located in less populous areas, indicated a stable work force.

Facilities experiencing recruitment and retention problems stated that higher starting salaries for new graduates and experienced therapists, ranging from $500 - $6,200 at non-Federal medical centers makes competing with them extremely difficult. This situation is aggravated further by additional salary flexibilities available in private hospitals, including "sign-up" bonuses, regular cost-of-living increases, and greater promotion opportunities. Additionally, they stated that fringe benefit programs at non-Federal medical centers offer such incentives as tuition assistance for continuing education, free health benefits, discounts on prescriptions, child care, and discounts on medical treatment at the facility.

Facility responses are consistent with those provided to survey questions concerning average pay and fringe benefits; nearly 63% of them stated that the VA was at a salary disadvantage with non-Federal medical centers and more than half stated that health benefit and tuition assistance programs put them at a disadvantage.

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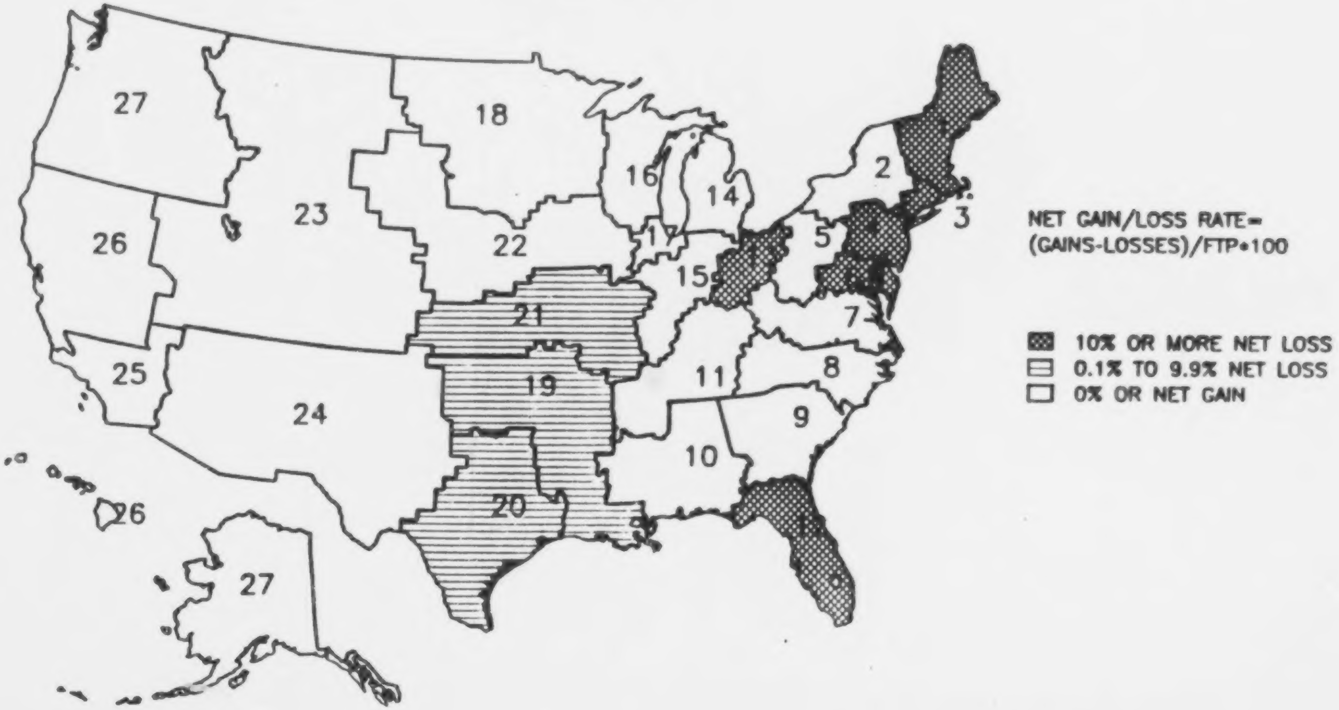
NET GAIN/LOSS RATE BY MEDICAL DISTRICT FOR OCCUPATIONAL THERAPISTS

As of October 1, 1986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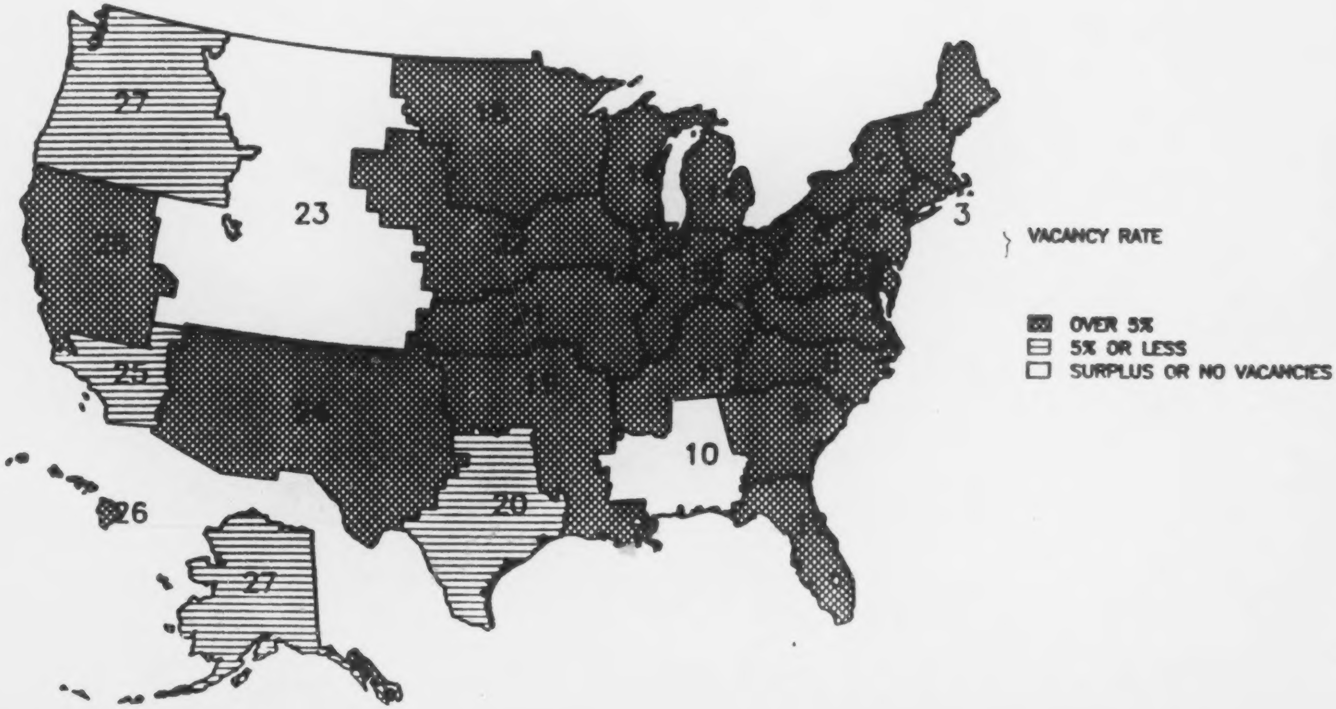
NET GAIN/LOSS RATE=
(GAINS-LOSSES)/FTP•100
▩ 10% OR MORE NET LOSS
▤ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN

Figure 8

VACANCY RATE BY MEDICAL DISTRICT
FOR OCCUPATIONAL THERAPISTS
As of October 1, 1986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VACANCY RATE
▩ OVER 5%
▤ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 9

Veterans Administration Medical Center Facilities

Staffing Index - Occupational Therapist

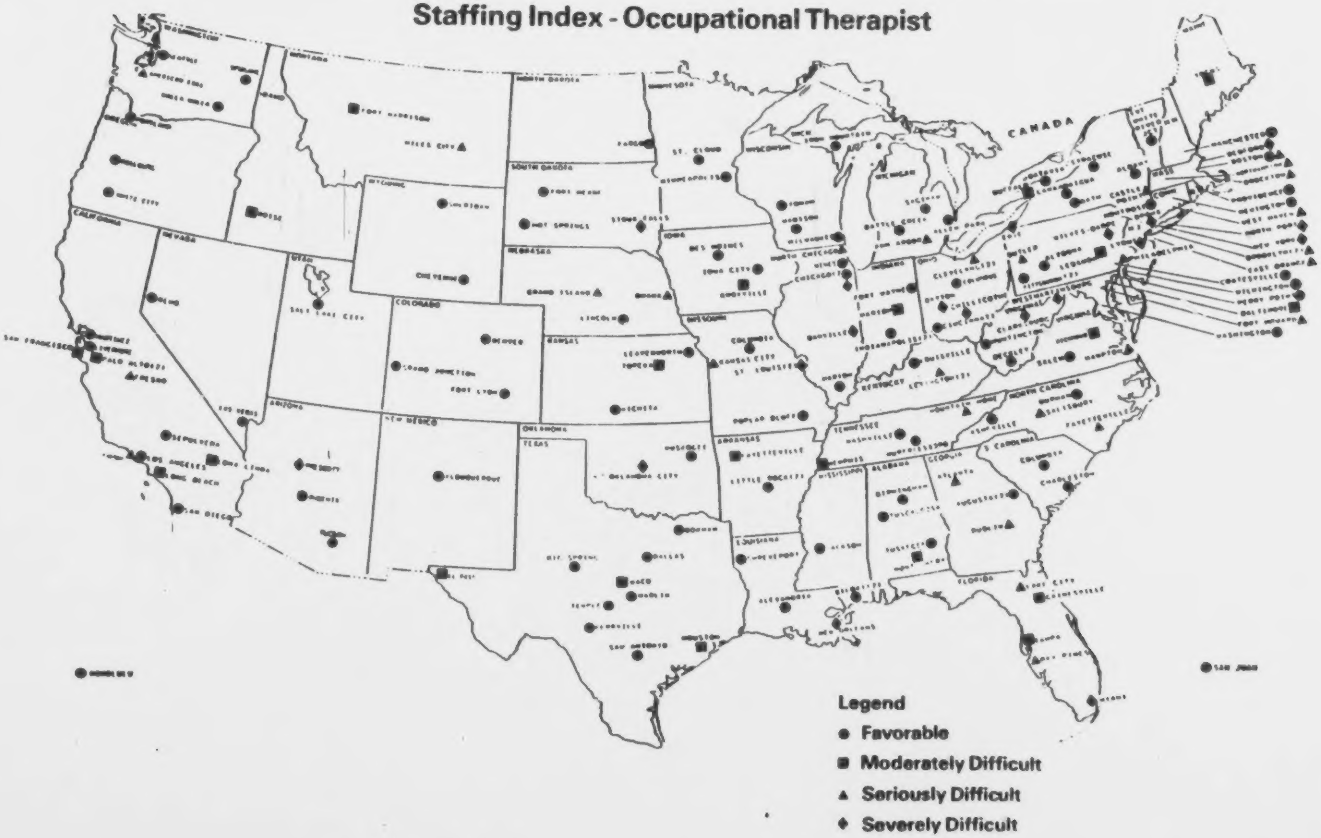

CANADA
Legend
● Favorable
■ Moderately Difficult
▲ Seriously Difficult
◆ Severely Difficult

Figure 10

PHARMACIST

Part A. HIGHLIGHTS

o DM&S-wide losses exceeded gains by 51, which resulted in a net loss rate of nearly 2%. Medical districts which reported losses are primarily concentrated in the mid-Atlantic states, Florida, and Wisconsin. Only 22 medical facilities (13%) reported net loss rates of 10% or more. About 48% of VA medical facilities are experiencing favorable recruitment and retention conditions. Moderate staffing difficulties are being experienced in more than 26% of the facilities. Within a medical district or city, there are variances in facilities' ability to staff pharmacist positions.

o Most facilities (88.3%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

o About 50% of the pharmacist losses are attributed to reasons other than pay at the same level of responsibility.

o Over 80% of the facilities reported that pharmacists working in local medical facilities receive higher salaries than their VA counterparts.

o Nearly 74% of the facilities reported that the regularly scheduled general pay increases offered by private medical facilities placed them at a disadvantage in hiring and retaining pharmacists.

o Only 30% of those who respond to VA recruitment efforts decline employment because of salary.

o Federal fringe benefits generally are competitive with those provided by private sector facilities although in some locales, health insurance and tuition assistance benefits place the VA at a disadvantage.

o On the average, only 4% of the pharmacy students trained at a VA facility are employed by the facility.

o 27% of those who apply for VA employment are found unacceptable by the Agency.

Part B. Analysis of Responses

1. Staffing Data

The staffing index shows that 47.9% of VA medical facilities are experiencing favorable recruitment and retention conditions for pharmacists. The range of conditions and percentage of facilities experiencing them are shown below:

FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
47.9%	26.3%	19.2%	6.6%

Agency-wide losses exceeded gains by 51 pharmacists (621 compared to 570) for a net loss rate of nearly 2%. Medical districts which reported net losses are primarily concentrated in the mid-Atlantic states, Florida, and Wisconsin. Four medical districts reported net loss rates of 10% or higher. The turnover rate for pharmacists is nearly 22.6% and the vacancy rate is 2.7%.

Losses are generally concentrated in areas of high population density. The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced are shown below:

Less than 50,000	+7.7%
50,000 to 100,000	+4.2%
100,000 to 250,000	-0.5%
Over 250,000	-4.7%

Psychiatric facilities which have a broader primary service area than medical and surgical facilities reported a net gain rate of almost 3%.

Most facilities (88.3%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

2. Reasons for Losses

Nearly 43% of pharmacist losses were attributed to opportunities for higher pay at the same level of responsibility. Detailed reasons for losses are as follows:

Higher pay at same level of responsibility	42.5%
Relocation	12.6%
Higher pay for a higher level of responsibility	7.3%
Retirement	5.3%
Private practice	5.2%
Family reasons	4.4%
Changes occurring in Federal employment, e.g., retirement coverage, benefits, etc.	4.1%
Educational reasons	3.6%
Different type of patient care environment	2.5%
Same pay, but better fringe benefits	1.8%
Involuntary separation	1.6%

Higher-level position without higher pay	1.0%
Changes of job description	0.8%
Other	7.4%

3. Sources of Gains

The sources of gains and percentages are as follows:

Private sector medical facility	21.5%
Other VA facility	20.4%
Recent graduate	16.0%
Other medical-related employment (private practice, consultant, etc.)	15.7%
Non-VA Federal medical facility	8.1%
Non-medical employment	7.4%
Unemployment	5.9%
Military service	0.8%
Other	4.2%

4. Private Sector Pay Comparison

More than 80% of the respondents stated that pharmacists working in non-Federal medical facilities receive salaries which are higher than those earned by VA pharmacists performing comparable work.

Pay differential categories and percentages are as follows:

- Much more ($4,000 per annum or more) at other facilities	54.1%
- More (up to $4,000 per annum more) at other facilities	28.0%
- Comparable	8.3%
- Less (up to $4,000 less) at other facilities	6.4%
- Much less ($4,000 per annum or more) at other facilities	3.2%

5. Pay Practices at Other Local Medical Facilities

Nearly 74% of VA facilities reported that regularly scheduled general pay increases at other medical facilities in their areas placed them at a disadvantage in hiring and retaining pharmacists. The pay practices cited and percentages are as follows:

Regular Pay Increases	73.6%
Overtime	23.8%
Weekend Premium Pay	23.1%
On-Call	22.5%
Holiday Shift	19.7%
Other	50.0%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities. However, VA facilities reported disadvantages on health insurance (67.1%) and tuition assistance (62.8%). (Some medical districts reported 100% on both of these factors.)

Facilities reported that day care for children (37.2%), retirement programs (30.3%), incentive awards (28.4%), annual leave (13.6%), and sick leave (11%) put them at a disadvantage with non-Federal medical facilities. Miscellaneous reasons were cited 37.1% of the time.

7. Necessity for Alternative Methods of Coverage

Almost 40% of facilities reported that they needed alternative methods of coverage, e.g., additional shifts, expanded use of pharmacy technicians, overtime on a recurring basis, the use of temporary and intermittent pharmacists, etc. Every region reported using alternative methods and employing people in other occupations to provide coverage. The Southeastern and Southwestern Regions experienced the greatest need for providing alternative coverage, while the Mid-Atlantic Region had the largest percentage of other occupations providing the coverage. Regions and percentages are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	30.4	30.4
Mid-Atlantic	44.4	42.9
Southeastern	60.0	35.0
Great Lakes	27.3	9.1
Mid-Western	30.8	11.5
Western	34.8	26.1
Southwestern	54.5	13.1

8. Educational Institution Affiliations

Over 52% of the medical facilities are affiliated with schools of pharmacy, and an average of 1,300 pharmacy students were trained annually in fiscal years 1984-86. The average number of students who accepted employment at the facilities where they trained in fiscal years 1984-86 was 44. While the ratio of hires to trainees in the medical districts ranged from 0% to 17.6%, high ratios generally represented low actual hires. For example, the highest rate was in a district which hired 3 of their 17 students; and 10 medical districts trained 260 students and hired none.

9. Recruitment Techniques and Their Effectiveness

Newspaper advertising was the most frequently used technique with 108 facilities indicating that they had used this means at least once, and 53 facilities reported using advertising 4 or more times. Advertisements resulted in applications being received by 92 facilities, nearly 4 times the number of the next highest source. This suggests that advertising in local newspapers is a very effective recruiting technique.

Nearly 60% of pharmacist applications received by facilities were from the Special Examining Unit in Richmond, while the remainder were from other sources such as newspaper advertising and professional meetings. Facilities in southern California received the most applications (160) while facilities in Indiana reported receiving none at all. Other districts received from 9 to 86 applications. Recruitment techniques and responses are as follows:

Recruitment Techniques	Facilities Using 1-3 Times	Facilities Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Newspaper Ads	55	53	108	92
College Visits	65	13	78	26
Prof. Meetings	48	22	70	21
Prof. Associations	40	18	58	20
Pamphlets	20	19	39	14
Job Fairs	52	9	61	13
Prof. Journals	33	5	38	11

10. Special Pay Rates

Exactly 72% of the facilities responded that they have considered requesting special pay rates. At least one facility in every medical district and all facilities in nine medical districts in southern and mid-Atlantic states reported that they have considered requesting special pay rates.

Of the 81 facilities responding to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund the additional cost?", 2 indicated that the decision was completely affected by the requirement; 17 said that the decision was partly affected by the requirement; and 62 reported that the decision was not affected by the requirement.

The helpfulness of special pay in resolving problems was assessed by 34 facilities with authorizations in effect. The responses are as follows:

Helpful	6
Partially helpful	24
Not helpful	4

As of October 1, 1986, 37 facilities were authorized special salary rates, and 18 new requests and 11 requests for increases were pending consideration in Central Office.

11. Applicant Responses

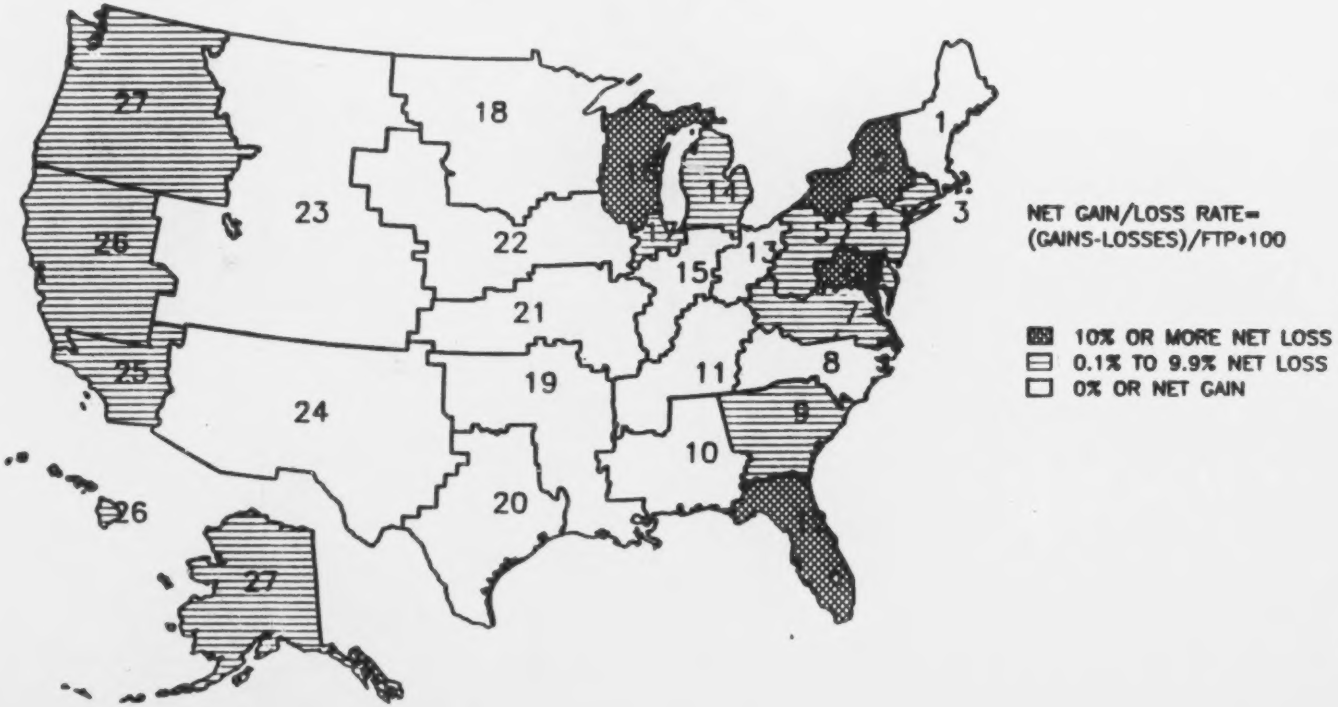
Facilities hired 29% of available applicants. Seven districts were able to hire 40% or more applicants, while the same number hired 20% or less. Facilities reported that 27% of the applicants were not selected for miscellaneous reasons, including suitability and previous work records. Of the 44% of the applicants who declined employment, the reasons and percentages are as follows:

Salary	68.2%
Job Factors	4.5%
Recruitment Delays	2.3%
Other	25.0%

12. Comments

Additional comments to the survey were provided by 75 of the 167 facilities surveyed. Of those, 67 facilities indicated experiencing staffing problems and cited the primary problem as salary rates, and 3 facilities reported no staffing problems at all. Most of the salary comments included references to special pay as a necessity or, in the case of facilities which had only recently received special pay authorization, as a measure by which they hoped to alleviate recruitment problems.

NET GAIN/LOSS RATE BY MEDICAL DISTRICT
FOR PHARMACISTS
As of October 1, 1986


NET GAIN/LOSS RATE=
(GAINS-LOSSES)/FTP•100
▩ 10% OR MORE NET LOSS
▤ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN
1
2
3
4
5
7
8
9
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27

Figure 11

VACANCY RATE BY MEDICAL DISTRICT
FOR PHARMACISTS
As of October 1, 1986

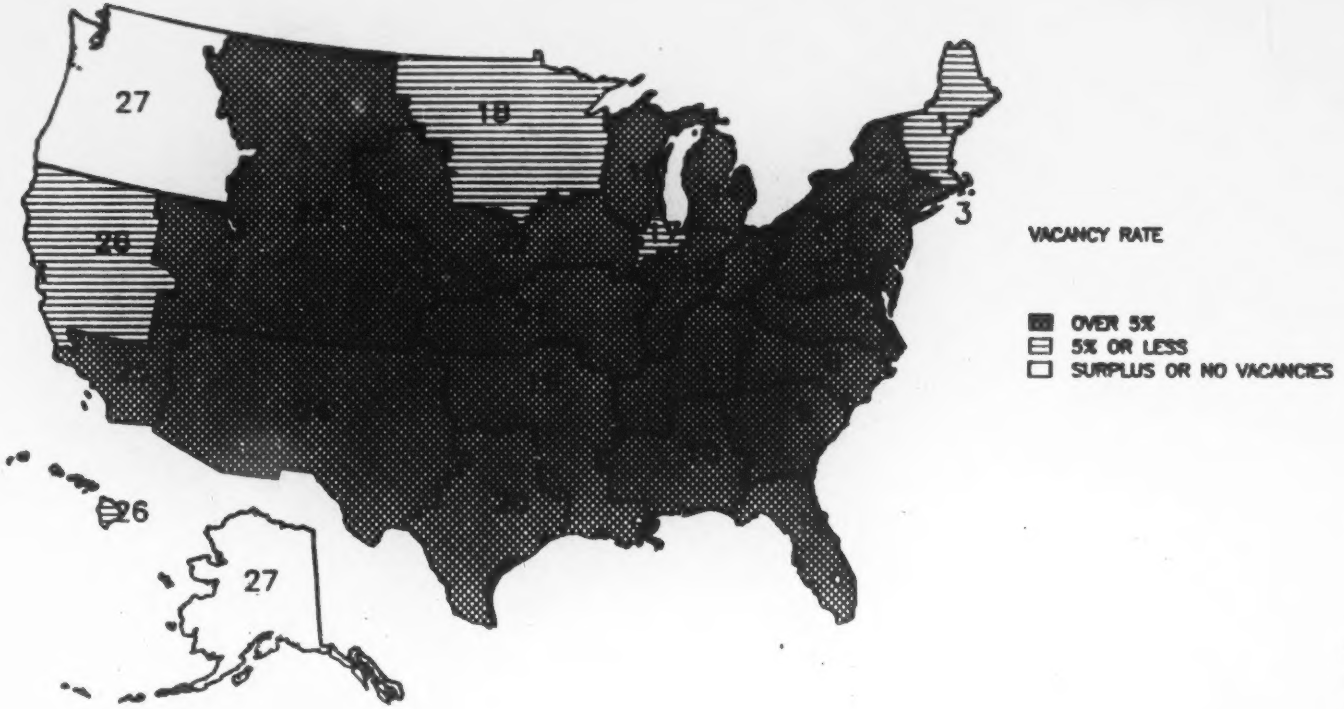
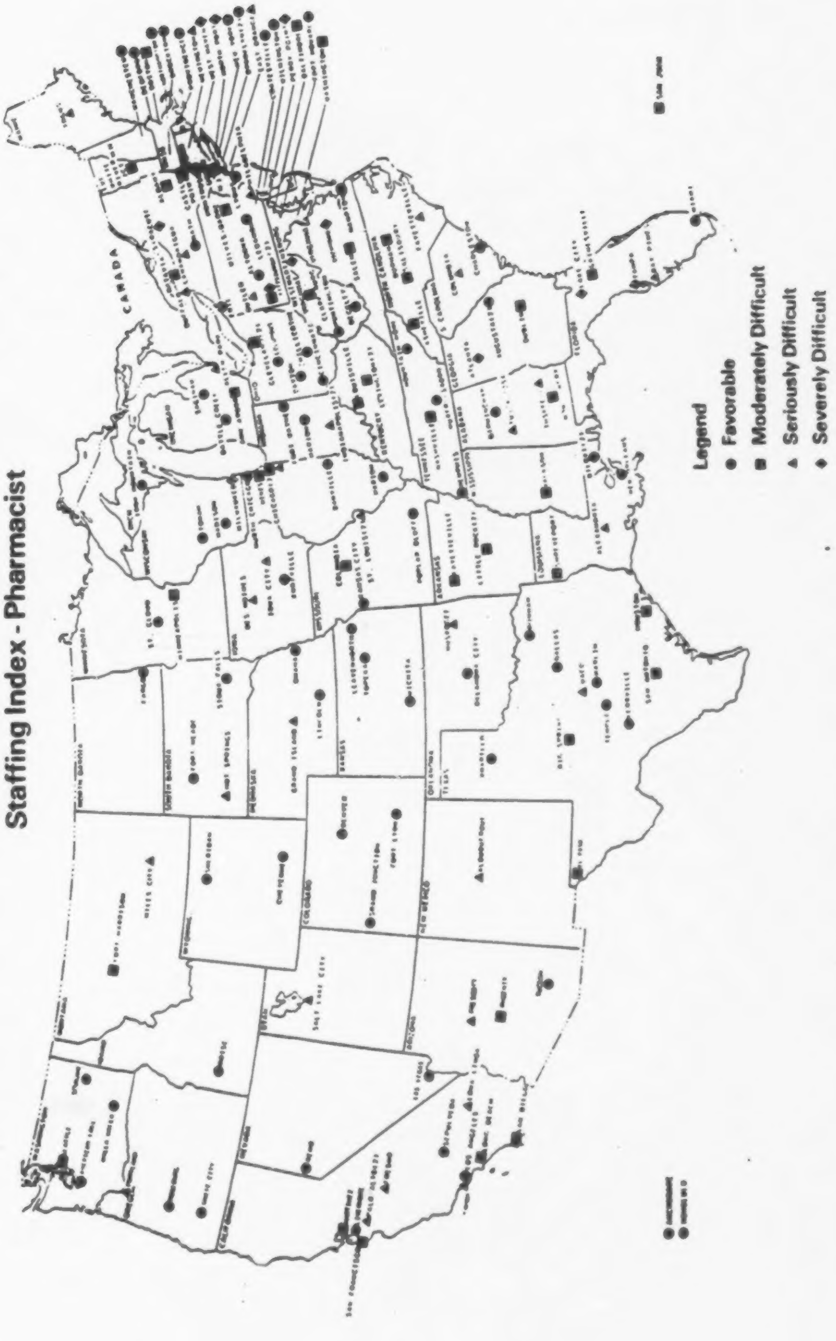

27
18
20
1
3
26
27
VACANCY RATE
▩ OVER 5%
▤ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 12

Figure 13



Veterans Administration Medical Center Facilities

Staffing Index - Pharmacist

CANADA
Legend
● Favorable
■ Moderately Difficult
▲ Seriously Difficult
◆ Severely Difficult

PHYSICAL THERAPIST

Part A. HIGHLIGHTS

o DM&S-wide losses exceeded gains by 21 for a net loss rate of nearly 2%. Medical districts which reported losses were found throughout the VA system including states from New York to Florida, the Great Lakes area, and the lower Mississippi valley, with 34 medical facilities (20%) reporting net loss rates. Within a medical district or city, there are variances in facilities' ability to staff physical therapist positions.

o Most facilities (91%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

o About 30% of physical therapist losses are attributed to opportunities for higher pay at the same level of responsibility.

o More than 83% of the facilities reported that physical therapists working in local medical facilities receive higher salaries than their VA counterparts.

o Nearly 64% of the facilities reported that the regularly scheduled general pay increases offered by private medical facilities placed them at a disadvantage in hiring and retaining physical therapists.

o 40% of those who respond to VA recruitment efforts decline employment because of salary.

o Federal fringe benefits generally are competitive with those provided by private sector facilities, although in some locales health insurance and tuition assistance benefits place the VA at a disadvantage.

o On the average, less than 3% of the physical therapy students trained at a VA facility are hired by the facility.

o 19% of those who apply for VA employment are found to be unacceptable by the Agency.

o Many facilities reported that physical therapist positions have been vacant for lengthy periods. Facilities unable to recruit physical therapists are utilizing corrective therapists and physical therapy assistants.

Part B. Analysis of Responses

1. Staffing Data

The staffing index shows that 41.9% of the facilities are experiencing favorable recruitment and retention conditions for physical therapists. The range of conditions and percentage of facilities experiencing them are shown below:

FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
41.9%	23.7%	23.1%	11.3%

Agency-wide losses exceeded gains by 21 physical therapists (144 compared to 123) for a net loss rate of nearly 2%. Medical districts which reported net losses are primarily concentrated in the eastern half of the country. Eight medical districts reported net loss rates of 10% or higher. The turnover rate for physical therapists is 26.5%. The vacancy rate is 22.9%.

The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced and percentages are shown below:

Less than 50,000	-6.3%
50,000 to 100,000	+28.6%
100,000 to 250,000	+2.9%
Over 250,000	-8.4%

Psychiatric facilities which have a broader primary service area than medical and surgical facilities reported a net loss of nearly 3%.

Most facilities (91%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

2. Reasons for Losses

Over 30% of physical therapist losses were attributed to opportunities for higher pay with the same level of responsibility. Detailed reasons for losses are as follows:

Higher pay at same level of responsibility	30.4%
Relocation	11.1%
Educational reasons	8.3%
Different type of patient care environment	7.8%
Higher pay for a higher level of responsibility	7.8%
Retirement	6.9%
Private practice	4.6%
Family reasons	4.6%
Same pay but better fringe benefits	3.2%
Changes occurring in Federal employment e.g., retirement coverage, benefits, etc.	2.3%

Involuntary separation	1.9%
Higher-level position without higher pay	0.9%
Changes of job description	0.9%
Other	9.3%

3. Sources of Gains

The sources of gains and percentages are as follows:

Private sector medical facility	32.8%
Recent graduate	28.2%
Other medical related employment (private practice, consultant, etc.)	14.5%
Other VA facility	11.5%
Unemployment	4.6%
Non-medical employment	3.8%
Military service	2.3%
Non-VA Federal medical facility	1.5%
Other	0.8%

4. Private Sector Pay Comparison

More than 83% of the respondents stated that physical therapists working in local non-Federal medical facilities receive salaries which are higher than those earned by VA physical therapists performing comparable work.

Pay differential categories and percentages are as follows:

- Much more ($4,000 per annum or more) at other facilities	47.1%
- More (up to $4,000 per annum more) at other facilities	35.9%
- Comparable	11.1%
- Less (up to $4,000 less) at other facilities	3.9%
- Much less ($4,000 per annum or more) at other facilities	2.0%

5. Pay Practices at Other Local Medical Facilities

Nearly 64% of the facilities reported that regularly scheduled general pay increases at other medical facilities in their areas placed them at a disadvantage in hiring and retaining physical therapists. The pay increases cited and percentages are as follows:

Regular Pay Increases	63.4%
Overtime	16.2%
On-Call	14.6%
Weekend Premium Pay	14.5%
Holiday Shift	9.5%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities for physical therapists. However, on tuition assistance (72.1%) and health insurance (67.6%) facilities reported disadvantages. (Some medical districts reported 100% on both of these factors.)

Facilities reported that day care for children (30.9%), retirement programs (29.1%), incentive awards (23.4%), annual leave (15.2%) and sick leave (6.5%) put them at a disadvantage with non-Federal medical facilities. Miscellaneous reasons were cited 36% of the time.

7. Necessity for Alternative Methods of Coverage

Almost 28% of facilities reported that they needed alternative methods of coverage, e.g., additional shifts and contracting out. Every region reported using alternative methods and employing other occupations to provide coverage. The Great Lakes and Western Regions experienced the greatest need for providing alternate coverage, while all regions made considerable use of other occupations to provide such coverage. Regions and percentages are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	16.7	29.2
Mid-Atlantic	28.0	34.6
Southeastern	14.3	28.6
Great Lakes	45.0	35.0
Mid-Western	33.3	36.0
Western	42.9	42.9
Southwestern	15.0	20.0

8. Educational Institution Affiliations

Almost 48% of the VA's medical facilities are affiliated with schools of physical therapy and on average, over 1,200 students were trained annually in fiscal years 1984-86. The average number of students who accepted employment at the facility where they were trained in fiscal years 1984-86 was 29. While the ratio of hires to trainees in the medical districts ranged from 0% to 21.4%, high ratios generally represented low actual hires. For example, the highest rates were in 9 medical districts which hired 3 of their 14 students, and 9 medical districts trained 274 students and hired none.

9. Recruitment Techniques and Their Effectiveness

Newspaper advertising was the most commonly used recruitment technique with 76 using it at least once and 30 facilities using it 4 or more times. More facilities (41) reported receiving applications from this source than from any of the others identified below. Professional journals were the second most utilized and also the second most productive source of applications.

Recruitment techniques and responses are as follows:

	Facilities Using 1-3 Times	Facilities Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Newspaper Ads	76	30	106	41
Prof. Journals	71	18	89	26
College Visits	46	10	56	19
Prof. Meetings	48	11	59	12
Prof. Associations	59	13	72	11
Job Fairs	55	3	58	4
Pamphlets	27	11	38	4

10. Special Pay Rates

More than 58% of the facilities responded that they have considered requesting special pay rates.

Of the 87 facilities responding to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund the additional cost?", 5 indicated that the decision was completely affected by the requirement; 13 said the decision was partly affected by the requirement; and 69 reported that the decision was not affected by the requirement.

The helpfulness of special pay in resolving problems was assessed by 41 facilities with authorizations in effect. The responses are as follows:

Helpful	4
Partially helpful	19
Not helpful	18

As of October 1, 1986, 49 facilities were authorized special salary rates for physical therapists, and 3 new requests and 9 requests for increases were pending consideration in Central Office.

11. Applicant Responses

Facilities hired 27% of the available applicants. Seven districts were able to hire 40% or more of applicants, while the same number hired 20% or less. Facilities reported that 19% of the applicants were not selected for failure to meet qualification requirements and for miscellaneous reasons, including suitability and previous work records. Of the 55% of the applicants who declined employment, the reasons and percentages are as follows:

Salary	72.7%
Job Factors	5.5%
Working Conditions	3.6%
Recruitment Delays	1.8%
Other	16.4%

12. Comments

Additional comments to the survey were provided by 62 facilities (37%). Of these, 48 (77.4%) indicated that salary and fringe benefit programs were primarily responsible for recruitment and retention difficulties; and 14 facilities (22.6%) stated concerns about their individual facilities.

Several facilities mentioned that overtime rates, holiday pay and shift differential rates, and annual and sick leave accrual rates were comparable to non-Federal medical centers. However, they indicated that higher starting salaries for new graduates (ranging from $1,800 - $5,000) and experienced therapists (ranging from $2,000 - $10,000) at non-Federal medical centers makes competing with them extremely difficult. This situation is aggravated further by additional salary flexibilities available in private hospitals, including "sign-up" bonuses and regular cost-of-living adjustments. Fringe benefit programs at non-Federal medical centers include such incentives as tuition assistance for continuing education, free health benefits, and discounts on prescriptions and medical care.

Many facilities reported that their physical therapist positions have been vacant for lengthy periods. They also stated that they are making greater use of corrective therapists and physical therapy assistants because of their inability to hire physical therapists. In several facilities, staff shortages have reduced or eliminated student training programs.

While the conversion of physical therapists to Title 38 has offered some advantages, several facilities stated that it does little for those who have been in Federal service a number of years and, consequently, are in higher steps of their grades. Due to pay compression, special pay rates result in entry-level therapists making almost as much as long-term employees.

Although a number of facilities stated that special salary rates are helpful, several indicated that the requests were sometimes not approved in their entirety (e.g., entry-level grades, but not journeyman level; lower salaries than requested; etc.).

NET GAIN/LOSS RATE BY MEDICAL DISTRICT
FOR PHYSICAL THERAPISTS
As of October 1, 1986

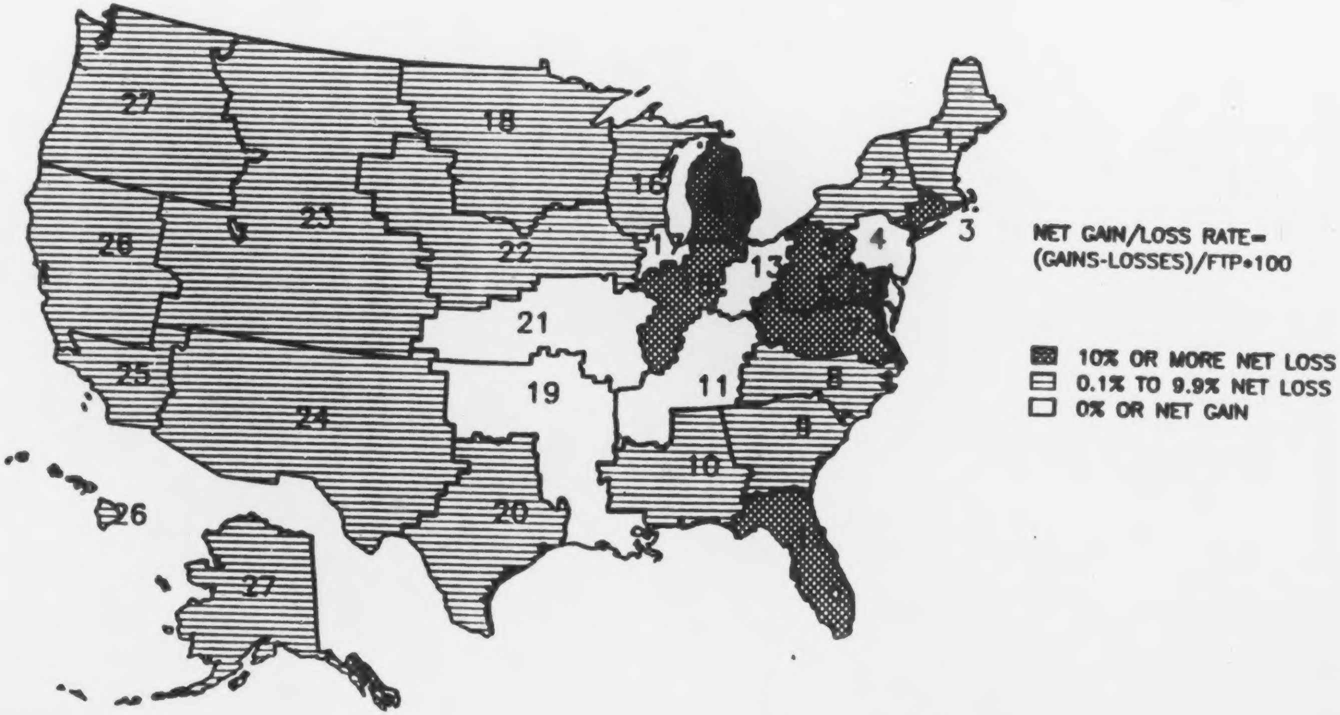

27
18
16
28
23
22
17
13
4
2
1
3
21
25
19
11
8
24
9
10
26
20
27
NET GAIN/LOSS RATE=
(GAINS-LOSSES)/FTP*100
▨ 10% OR MORE NET LOSS
▤ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN

Figure 14

VACANCY RATE BY MEDICAL DISTRICT
FOR PHYSICAL THERAPISTS
As of October 1, 1986

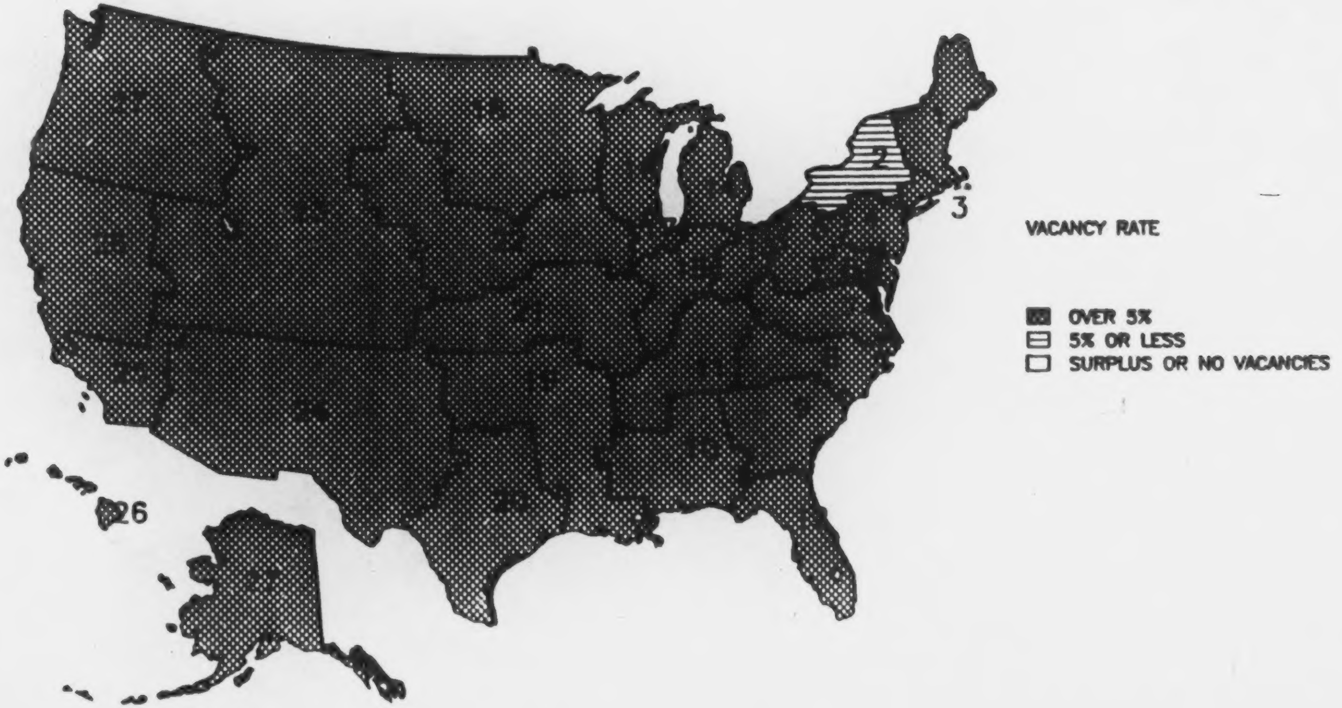

2
3
26
VACANCY RATE
▩ OVER 5%
▤ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 15

Veterans Administration Medical Center Facilities

Staffing Index - Physical Therapist

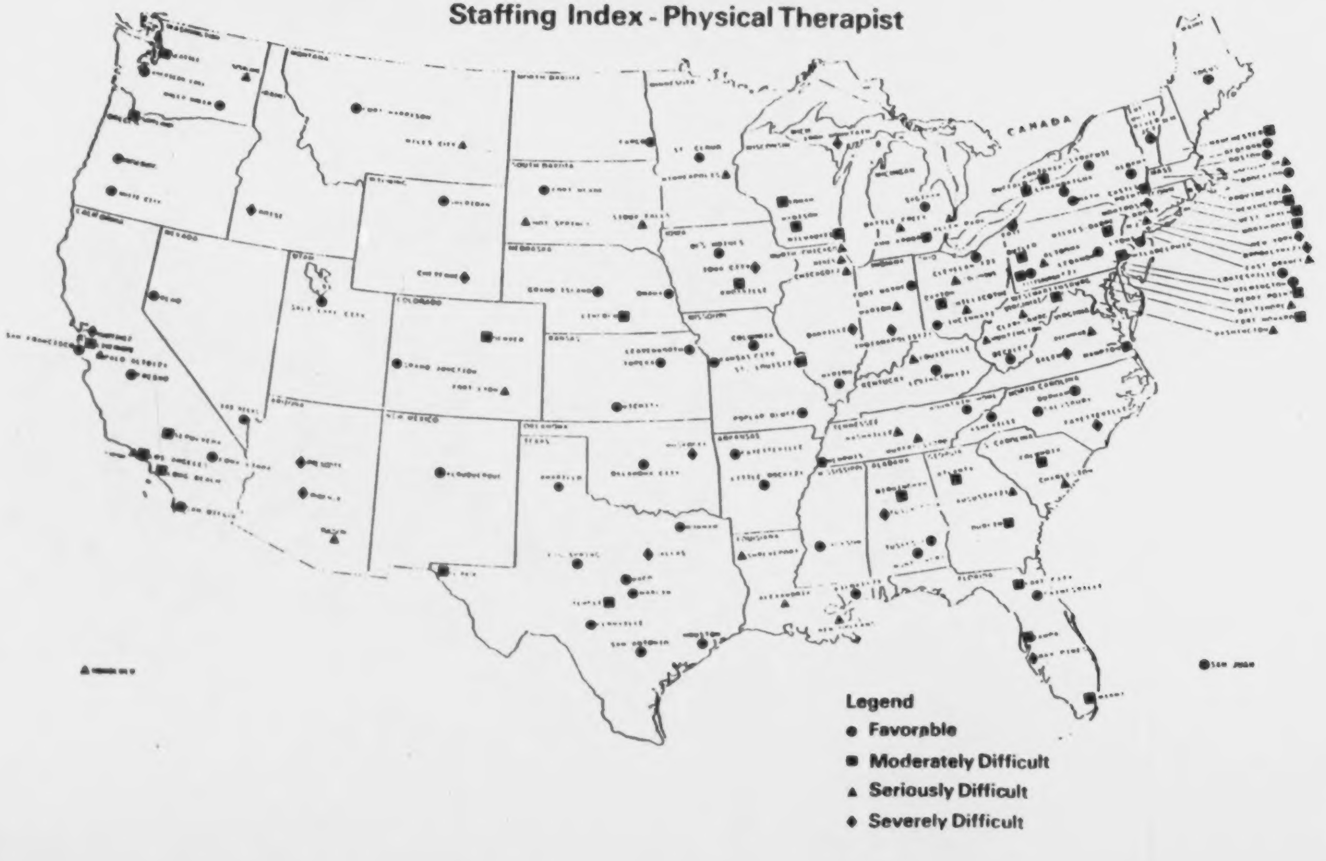

CANADA
Legend
● Favorable
■ Moderately Difficult
▲ Seriously Difficult
◆ Severely Difficult

Figure 16

ANALYSIS OF SURVEY RESPONSES BY OCCUPATION WITH ILLUSTRATIONS SHOWING NET GAIN OR LOSS RATES AND VACANCY RATES

GROUP II

CERTIFIED/REGISTERED RESPIRATORY THERAPIST

Part A. HIGHLIGHTS

- The data furnished by most facilities covered certified/registered respiratory therapists as well as other employees, such as inhalation therapists and medical machine technicians, whose primary function is to provide respiratory therapy.

- DM&S-wide gains exceeded losses by 29 for a net gain rate among respiratory therapists of nearly 2.9%. Of the 144 facilities providing data on respiratory therapists, 23 (or 16.0%) reported net losses. These facilities are concentrated primarily in California and the northeastern states. About 36% of responding facilities are experiencing recruitment and retention problems for respiratory therapists. Moderate staffing difficulties are being experienced by 13.2% of the facilities.

- Most facilities (87.8%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

- 38% of respiratory therapist losses are attributed to opportunities for higher pay at the same level of responsibility. Approximately 14% leave to relocate.

- Nearly 50% of the facilities reported that respiratory therapists working in local non-Federal medical facilities receive higher salaries than their VA counterparts.

- Nearly 54% of the facilities reported that the regularly scheduled general pay increases offered by private medical facilities placed them at a disadvantage in hiring and retaining respiratory therapists.

- Nearly 58% of those who decline employment cite salary as the reason.

- Federal fringe benefits generally are competitive with those provided by private sector facilities although in some locales, health insurance and tuition assistance benefits place the VA at a disadvantage.

- On the average, less than 4% of the respiratory therapy students trained at VA facilities accept employment at the facilities where they are trained.

- 39% of those who apply for VA employment are found unacceptable by the Agency.

- Nearly 59% of the respiratory therapists hired are recruited from private sector medical facilities.

- Less than 10% of the respiratory therapist new hires are recent graduates.

Part B. Analysis of Responses

1. Staffing Data

Of the 167 facilities surveyed, 144 provided data for 1,002 full-time permanent (FTP) employees in the respiratory therapy occupational area. As of October 1, 1986, more than 1,100 FTP employees broadly categorized as respiratory therapists and technicians were employed in the Agency, 781 of whom were certified/registered respiratory therapists. In addition to certified/registered respiratory therapists, most of the responding facilities provided data on other employees whose primary function is to provide respiratory therapy such as inhalation therapy technicians and medical machine technicians.

The staffing index shows that 63.9% of the facilities are experiencing favorable staffing conditions for respiratory therapists. The range of conditions and percentages of facilities experiencing them are shown below:

FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
63.9%	13.2%	9.7%	13.2%

Agency-wide gains for all respiratory therapists exceeded losses by 29 employees (242 compared to 213) for a net gain of 2.9%. The turnover rate for respiratory therapists is 21.3% and the vacancy rate is 15.9%. Facilities reporting net loss rates are concentrated in California and the northeastern states.

Losses are generally concentrated in areas of high population density. The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced and for psychiatric facilities (which typically have very large primary service areas) are shown below:

Less than 50,000	+13.6%
50,000 to 100,000	+10.0%
100,000 to 250,000	+ 8.4%
Over 250,000	- 3.2%
Psychiatric	+ 8.8%

Most facilities (87.8%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

2. Reasons for Losses

Facilities attributed 38% of their respiratory therapist losses to opportunities for higher pay at the same level of responsibility. Detailed reasons for losses are as follows:

Higher pay with same level of responsibility	38.0%
Relocation	14.1%
Family reasons	7.8%

Higher level position with higher pay	5.9%
Private practice	5.9%
Different type of patient care environment	5.9%
Involuntary separation	3.9%
Educational reasons	2.7%
Retirement	1.6%
Higher level position without higher pay	0.8%
Same pay, but better fringe benefits	0.0%
Changes of job description	0.0%
Changes occurring in Federal employment (e.g., retirement coverage, benefits, etc.)	0.0%
Other	13.4%

3. Sources of Gains

The sources of gains and percentages are as follows:

Private sector medical facility	58.9%
Recent graduate	9.9%
Other VA facility	8.3%
Other medical related employment (private practice, consultant, etc.)	6.3%
Non-medical employment	4.7%
Non-VA Federal medical facility	4.0%
Unemployment	4.0%
Military service	0.8%
Other	3.1%

4. Private Sector Pay Comparison

More than half (almost 51%) of the respondents stated that VA respiratory therapists receive salaries which are comparable to or greater than those earned by their counterparts in local non-Federal medical facilities.

Pay differential categories and percentages are as follows:

- Much more ($4,000 per annum or more) at other facilities	13.0%
- More (up to $4,000 per annum more) at other facilities	35.9%
- Comparable	35.9%
- Less (up to $4,000 less) at other facilities	14.5%
- Much less ($4,000 per annum or more) at other facilities	0.7%

5. Pay Practices at Other Local Medical Facilities

Nearly 54% of VA facilities reported that pay practices at other medical facilities put the VA at a disadvantage in hiring and retaining respiratory therapists. The pay practices cited and percentages are as follows:

Regularly Scheduled General Pay Increases	53.6%
On-Call	23.4%
Weekend Premium Pay	15.4%
Overtime	12.9%
Holiday Shift	7.3%
Other	28.4%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities. However, VA facilities reported disadvantages on tuition assistance (59.7%) and health benefits (52.4%). (Some medical districts reported 100% on both of these factors.)

Additionally, facilities reported that day care for children (24.8%); retirement programs (20%); incentive awards (14.3%); annual leave (8.7%); and sick leave (3.2%) put them at a disadvantage with non-Federal medical facilities. Miscellaneous reasons were cited 25.4% of the time.

7. Necessity for Alternative Methods of Coverage

About 25% of the facilities reported that they needed alternative methods of coverage, e.g., additional shifts, overtime on a recurring basis, the use of temporary and intermittent respiratory therapists, etc. Facilities in every region reported using alternative methods of coverage. Additionally, facilities in all but the Southeastern and Southwestern Regions reported using employees in other occupations such as registered nurses and nurse anesthetists to provide coverage. The Southeastern, Mid-Western and Western Regions experienced the greatest need for providing alternative coverage. The Western Region had the largest percentage of other occupations providing the coverage. The percentage of facilities by category in each region are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	19.0	14.3
Mid-Atlantic	22.7	12.5
Southeastern	29.4	0.0
Great Lakes	20.0	15.8
Mid-Western	30.4	12.5
Western	33.3	16.7
Southwestern	12.5	0.0

8. Educational Institution Affiliations

Over 33% of the VA's medical facilities are affiliated with schools of respiratory therapy and, on the average, over 650 students were trained annually in fiscal years 1984-86. The average number of students who accepted employment at the facilities where they were trained in fiscal years 1984-86 was 25. While the ratio of hires to trainees in the medical districts ranged from 0% to 14.3%, high ratios generally represented low actual hires. For example, the highest rate was in a northeastern medical district which hired one of their seven students. In 8 medical districts, 135 students were trained and none were hired.

9. Recruitment Techniques and Their Effectiveness

Newspaper advertising was the most frequently used technique with 60 of the facilities indicating that they had used this means of advertising 1 to 3 times, and 10 reporting its use 4 or more times. These advertisements resulted in applications being received by 60 facilities. This was more than three times the number of the next highest source of applications, suggesting that advertising in local newspapers is a very effective recruiting technique.

Recruitment techniques and responses are as follows:

Recruitment Techniques	Facilities Using 1-3 Times	Facilities Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Newspaper Ads	60	10	70	60
Prof. Associations	21	5	26	17
Job Fairs	22	4	26	6
College Visits	23	2	25	10
Prof. Meetings	20	3	23	10
Prof. Journals	11	2	13	5
Pamphlets	4	1	5	2

10. Special Pay Rates

More than 14% of the facilities that responded to this question said that they have considered requesting special pay rates. These facilities are located in every region except the Southeastern Region.

Of the 108 facilities that responded to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund the additional cost?", 5 indicated that the decision was completely affected by the requirement; 10 said the decision was partly affected by the requirement; and 93 reported that the decision was not affected by the requirement.

As of October 1, 1986, one facility was authorized special rates for certified/registered respiratory therapists, and nine authorizations were in effect for inhalation therapy technicians. Five facilities assessed the helpfulness of special rates. The one facility with special rates in effect for certified/registered respiratory therapists found that they were partially helpful in resolving staffing problems. The responses for both occupational categories follow:

Helpful	2
Partially helpful	3
Not helpful	0

There were no new requests under Central Office consideration for either of these occupational categories as of October 1, 1986.

11. Applicant Responses

Facilities hired 35% of available applicants. Eight districts were able to hire 40% or more of the applicants, while 5 districts hired 25% or less. Facilities reported that 39% of the applicants were not selected for failure to meet qualification requirements and for miscellaneous reasons, including suitability and previous work records. Of the 26% of the applicants who declined employment, the reasons and percentages are as follows:

Salary	57.6%
Job Factors	11.6%
Working Conditions	7.7%
Recruitment Delays	7.7%
Other	15.4%

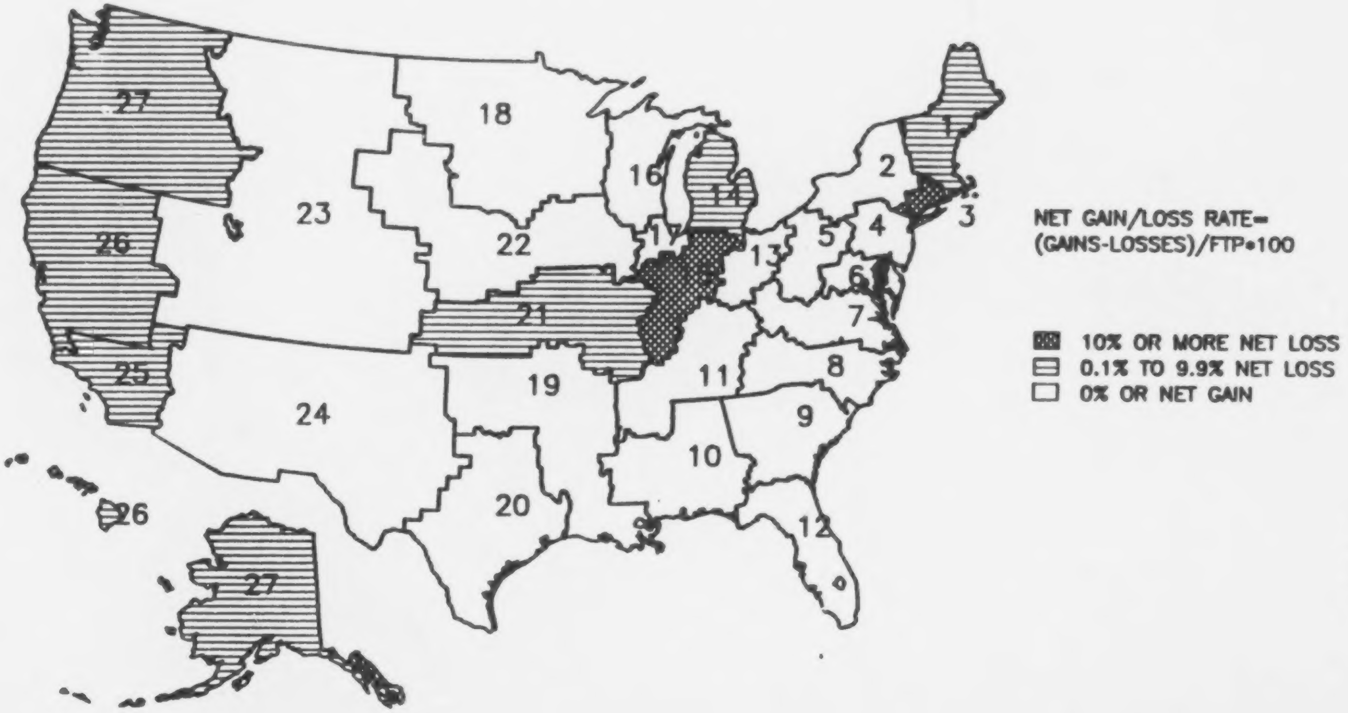
12. Comments

Additional comments to the survey were provided by 37 facilities. Of these, eight facilities located in less populous areas indicated that they had no staffing problems. By comparison, eight facilities located in metropolitan areas indicated that salaries and fringe benefits provided by private sector facilities were primarily responsible for recruitment and retention difficulties.

Several facilities that had been experiencing staffing difficulties prior to the conversion of certified/registered respiratory therapists under Title 38 indicated that recruitment and retention of them did not improve after the conversion. Conversely, facilities that had been experiencing favorable staffing conditions prior to the conversion stated that the quality of applicants had improved.

Many facilities reported that staff coverage for the respiratory function is routinely provided by inhalation therapy technicians and medical machine technicians. Additionally, some facilities reported that registered nurses and nurse anesthetists provided coverage in this occupational area.

NET GAIN/LOSS RATE BY MEDICAL DISTRICT
FOR RESPIRATORY THERAPISTS
As of October 1, 1986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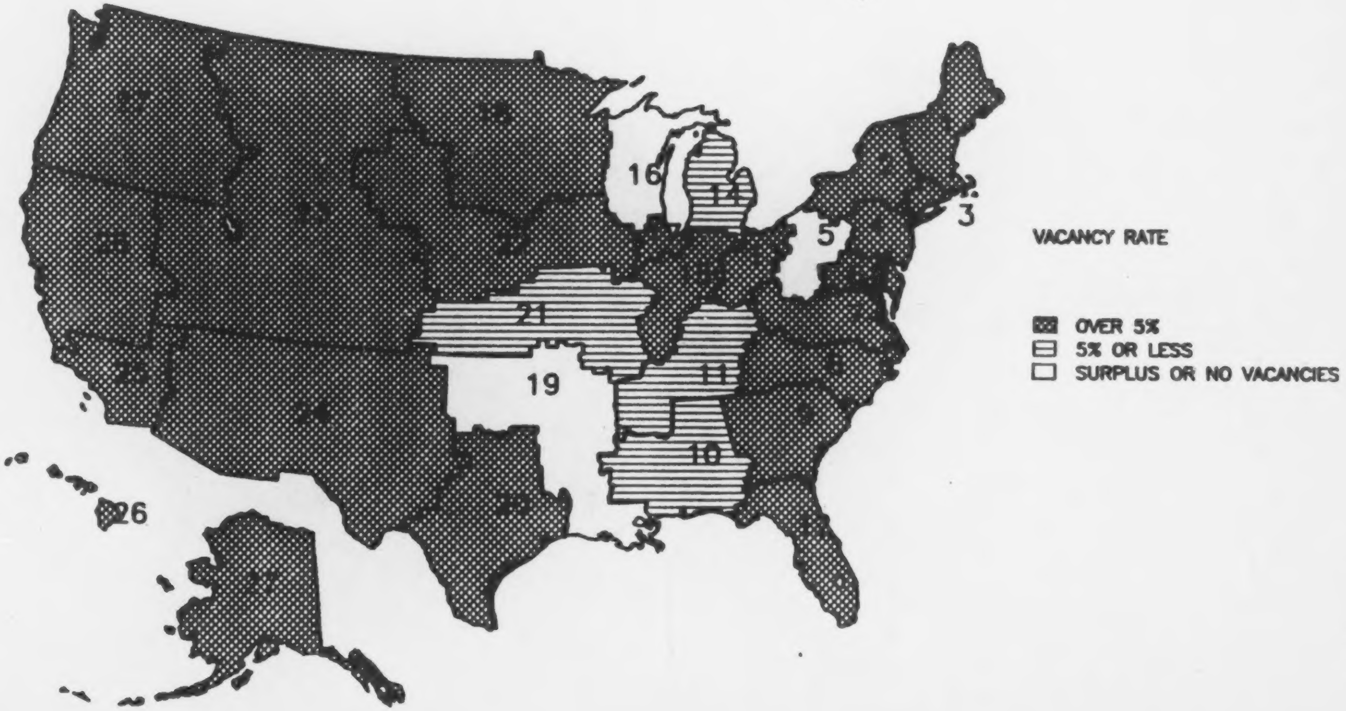
NET GAIN/LOSS RATE=
(GAINS-LOSSES)/FTP•100
▩ 10% OR MORE NET LOSS
▤ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN

Figure 17

VACANCY RATE BY MEDICAL DISTRICT
FOR RESPIRATORY THERAPISTS
As of October 1, 1986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VACANCY RATE
▩ OVER 5%
▤ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 18

DIAGNOSTIC RADIOLOGIC TECHNICIAN/TECHNOLOGIST

Part A. HIGHLIGHTS

o DM&S-wide losses exceeded gains by 30 for a net loss rate of 1.5%. Facilities reporting net losses are scattered throughout the country. About 63% of VA medical facilities are experiencing favorable recruitment and retention conditions. Moderate staffing difficulties are being experienced by 11.6% of the facilities. Within medical districts, there are significant variances in facilities' abilities to staff diagnostic radiologic technician/technologist positions.

o Most facilities (90%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

o Over 36% of diagnostic radiologic technician/technologist losses are attributed to opportunities for higher pay at the same level of responsibility. Approximately 13% leave to relocate.

o About 40% of the facilities reported that VA diagnostic radiologic technicians/technologists earn salaries which are comparable to or greater than those earned by their counterparts in local non-Federal medical facilities.

o 56% of the facilities reported that the regularly scheduled general pay increases offered by private medical facilities placed them at a disadvantage in hiring and retaining diagnostic radiologic technicians/technologists.

o Nearly 53% of the diagnostic radiologic technicians/technologists who decline employment with the VA cite salary as the reason.

o Federal fringe benefits generally are competitive with those provided by private sector facilities although in some locales, health insurance and tuition assistance benefits place the VA at a disadvantage.

o On the average, less than 7% of the diagnostic radiologic technicians/technologists trained at a VA facility are hired by the facility.

o 39% of the diagnostic radiologic technicians/technologists who apply for VA employment are found unacceptable by the Agency.

o Nearly 40% of the diagnostic radiologic technicians/technologists hired are recruited from private sector medical facilities.

o Nearly 14% of the diagnostic radiologic technician/technologist new hires are recent graduates.

Part B. Analysis of Responses

1. Staffing Data

Of the 167 facilities surveyed, 164 provided data for 2,059 full-time permanent diagnostic radiologic technicians/technologists.

The staffing index shows that 62.8% of the facilities are experiencing favorable recruitment and retention conditions for diagnostic radiologic technicians/technologists. The range of conditions and percentages of facilities experiencing them are shown below:

FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
62.8%	11.6%	12.2%	13.4%

Agency-wide losses exceeded gains by 30 (347 compared to 317) for a net loss rate of 1.5%. Facilities that reported net loss rates are scattered throughout the country. The turnover rate for diagnostic radiologic technicians/technologists is 16.9%. The vacancy rate is 5%.

Losses are generally concentrated in areas of high population density. The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced and for psychiatric facilities (which typically have very large primary service areas) are shown below:

Less than 50,000	0.0%
50,000 to 100,000	+ 1.3%
100,000 to 250,000	- 0.4%
Over 250,000	- 2.5%
Psychiatric	- 2.9%

Most facilities (90%) responded that sufficient funding and ceiling were available to achieve authorized staffing levels if candidates were available.

2. Reasons for Losses

Over 36% of diagnostic radiologic technician/technologist losses were attributed to opportunities for higher pay at the same level of responsibility. Detailed reasons for losses are as follows:

Higher pay with same level of responsibility	36.7%
Relocation	12.7%
Retirement	7.8%
Higher-level position with higher pay	7.3%
Same pay, but better fringe benefits	4.9%
Family reasons	3.6%
Private practice	3.6%
Different type of patient care environment	3.4%
Educational reasons	2.9%
Involuntary separation	2.3%

Changes of job description	0.8%
Higher-level position without higher pay	0.8%
Changes occurring in Federal employment (e.g., retirement coverage, benefits, etc.)	0.0%
Other	13.2%

3. Sources of Gains

The sources of gains and percentages are as follows:

Private sector medical facility	39.8%
Recent graduate	13.7%
Other VA facility	12.2%
Unemployment	8.8%
Non-VA Federal medical facility	7.9%
Other medical related employment (private practice, consultant, etc.)	6.7%
Non-medical employment	4.6%
Military service	2.7%
Other	3.6%

4. Private Sector Pay Comparison

Almost 60% of the respondents stated that diagnostic radiologic technicians/technologists working in local non-Federal medical facilities receive salaries which are higher than their VA counterparts performing comparable work.

Pay differential categories and percentages are as follows:

- Much more ($4,000 per annum or more) at other facilities	21.2%
- More (up to $4,000 per annum more) at other facilities	38.7%
- Comparable	31.0%
- Less (up to $4,000 less) at other facilities	4.2%
- Much less ($4,000 per annum or more) at other facilities	4.9%

5. Pay Practices at Other Local Medical Facilities

More than half of the VA facilities reported that pay practices at other medical facilities put the VA at a disadvantage in hiring and retaining diagnostic radiologic technicians/technologists. Reasons and percentages reported are as follows:

Regularly Scheduled General Pay Increases	56.0%
On-Call	31.4%

Weekend Premium Pay	27.0%
Holiday Shift	17.6%
Overtime	17.5%
Other	27.3%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities. However, VA facilities reported disadvantages on health insurance (55.3%) and tuition assistance (53.6%). (Some medical districts reported 100% on each of these factors.)

Facilities reported that day care for children (32.1%); retirement programs (21.7%); incentive awards (20.6%); annual leave 10.2%); and sick leave (7.3%) put them at a disadvantage with non-Federal medical facilities. Miscellaneous reasons were cited 23.8% of the time.

7. Necessity for Alternative Methods of Coverage

About 27% of the facilities reported that they needed alternative methods of coverage, e.g., additional shifts, overtime on a recurring basis, the use of temporary and intermittent diagnostic radiologic technicians/technologists, etc. Every region reported using alternative methods with the Northeastern and Western Regions having the greatest need for providing alternative coverage. The Western and Southwestern Regions had the largest percentages of other occupations providing such coverage. The percentage of facilities by category in each region are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	50.0	4.2
Mid-Atlantic	23.1	0.0
Southeastern	19.0	0.0
Great Lakes	14.3	0.0
Mid-Western	24.0	3.8
Western	50.0	4.5
Southwestern	9.1	4.5

8. Educational Institution Affiliations

More than 38% of the medical facilities are affiliated with schools which provide training in diagnostic radiology and, on the average, over 900 students were trained annually in fiscal years 1984-86. The average number of students who accepted employment at the facilities where they were trained in fiscal years 1984-86 was 60. The ratio of hires to trainees in the medical districts ranged from 0% to 85.7%. Five medical districts trained 87 students and hired none. Seven districts were able to recruit four or more students in fiscal year 1986.

9. Recruitment Techniques and Their Effectiveness

Newspaper advertising was the most frequently used technique with 55 facilities indicating that they had used this means at least once. Fifteen of these facilities reported they had used advertising four or more times.

Advertisements resulted in applications being received by 43 facilities, 3 times the number of the next highest source, suggesting that advertising in local newspapers is a very effective recruitment technique.

Recruitment techniques and responses are as follows:

Recruitment Techniques	Facilities Using 1-3 Times	Facilities Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Newspaper Ads	40	15	55	43
Prof. Meetings	23	7	30	7
Job Fairs	25	3	28	11
College Visits	21	5	26	14
Prof. Associations	18	6	24	8
Pamphlets	5	3	8	2
Prof. Journals	4	2	6	2

10. Special Pay Rates

Almost 25% of the facilities that responded to this question said that they have considered requesting special pay rates. Thirty-one of the 39 facilities that responded are located on the East or West coasts.

Of the 97 facilities that responded to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund the additional cost?", 5 indicated that the decision was completely affected by the requirement; 7 said the decision was partially affected by the requirement; and 85 reported that the decision was not affected by the requirement.

The helpfulness of special pay rates in resolving staffing problems was assessed by 12 facilities with authorizations in effect. The responses follow:

Helpful	2
Partially helpful	6
Not helpful	4

As of October 1, 1986, 14 facilities were authorized special salary rates for diagnostic radiologic technicians/technologists, and 5 new requests were under Central Office consideration.

11. Applicant Responses

Facilities hired 28% of available applicants. Four districts were able to hire 40% or more of the applicants, while 7 districts hired 20% or less.

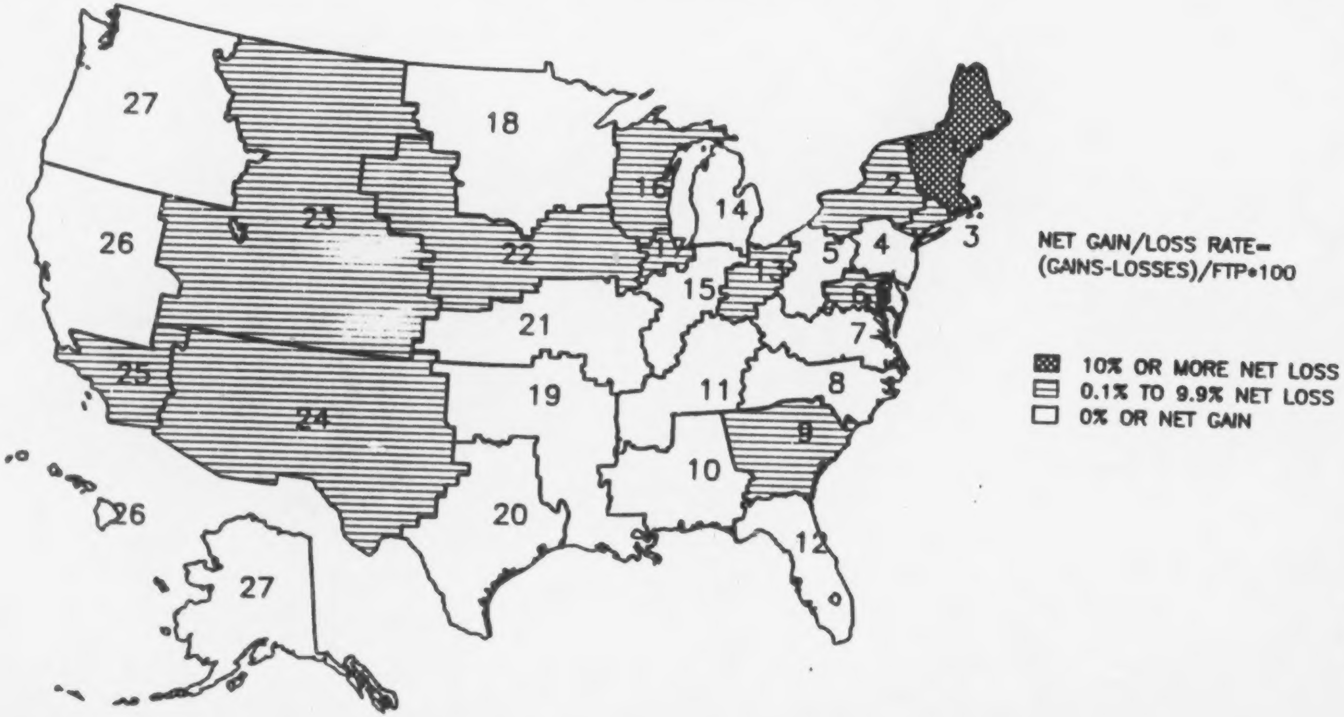
Facilities reported that 39% of the applicants were not selected for failure to meet qualification requirements and for miscellaneous reasons, including suitability and previous work records. Of the 34% of the applicants who declined employment, the reasons and percentages are as follows:

Salary	52.9%
Job Factors	5.9%
Recruitment Delays	2.9%
Working Conditions	0.0%
Other	38.3%

12. Comments

Additional comments to the survey were provided by 29 facilities. Of these, 17 indicated that salaries and fringe benefits were primarily responsible for recruitment and retention difficulties. Most of the facilities that reported difficulty are located in metropolitan areas. Generally, special pay rates were found to be helpful in less populous areas and not helpful in metropolitan areas. Other facilities reported that they were able to recruit entry-level candidates, but that these employees typically leave the VA after gaining experience for higher paying jobs in the private sector.

NET GAIN/LOSS RATE BY MEDICAL DISTRICT FOR DIAGNOSTIC RADIOLOGIC TECHNICIANS/TECHNOLOGISTS
As of October 1, 1986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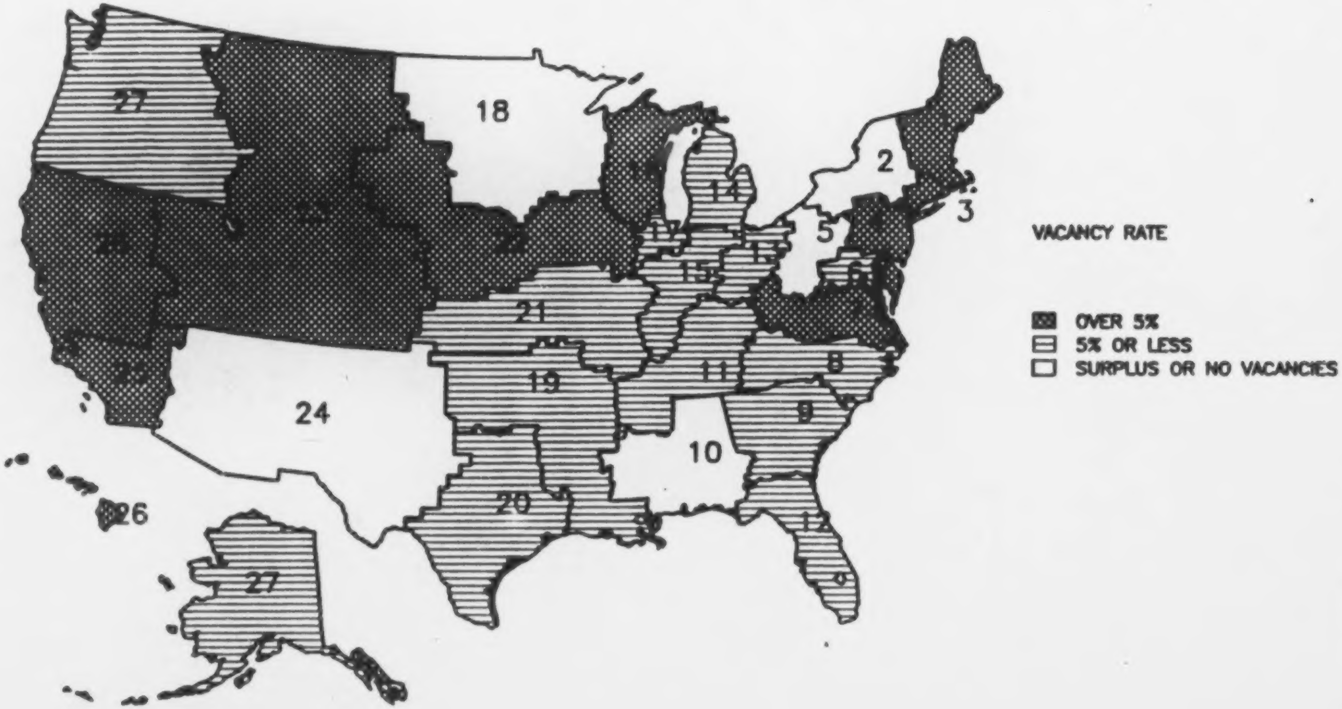
NET GAIN/LOSS RATE=
(GAINS-LOSSES)/FTP•100
▩ 10% OR MORE NET LOSS
▤ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN

Figure 19

VACANCY RATE BY MEDICAL DISTRICT FOR DIAGNOSTIC RADIOLOGIC TECHNICIANS/TECHNOLOGISTS

As of October 1, 1986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VACANCY RATE
▩ OVER 5%
▤ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 20

THERAPEUTIC RADIOLOGIC TECHNICIAN/TECHNOLOGIST

Part A. HIGHLIGHTS

o Most VA facilities do not utilize therapeutic radiologic technicians/technologists. DM&S-wide gains equaled losses for the 26 facilities which reported on this occupation. Net loss rates were reported by facilities located in New York, New Jersey, Illinois and Florida. About 65% of the facilities are experiencing favorable recruitment and retention conditions. Moderate staffing difficulties are being experienced by about 8% of the facilities. Within medical districts, there are significant variances in facilities' abilities to staff therapeutic radiologic technician/technologist positions.

o Most facilities (80.8%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

o Over 31% of the therapeutic radiologic technician/technologist losses are attributed to opportunities for higher pay at the same level of responsibility.

o 76% of the facilities reported that VA therapeutic radiologic technicians/technologists earn salaries which are less than those earned by their counterparts in local non-Federal medical facilities.

o Nearly 80% of the facilities reported that the regularly scheduled general pay increases offered by private medical facilities placed them at a disadvantage in hiring and retaining therapeutic radiologic technicians/technologists.

o Over 87% of the therapeutic radiologic technicians/technologists who decline employment with the VA cite salary as the reason.

o Federal fringe benefits generally are competitive with those provided by private sector facilities although in some locales, health insurance and tuition assistance benefits place the VA at a disadvantage.

o On the average, less than 6% of the students trained at a VA facility are hired by the facility.

o 29% of the therapeutic radiologic technicians/technologists who apply for VA employment are found unacceptable by the Agency.

o Significant numbers of therapeutic radiologic technicians/technologists leave their VA positions to relocate.

o Over 30% of the therapeutic radiologic technicians/technologists hired are recruited from private sector medical facilities.

o Over 18% of the therapeutic radiologic technician/technologist new hires are recent graduates.

Part B. Analysis of Responses

1. Staffing Data

Most VA facilities do not utilize therapeutic radiologic technicians/technologists. Of the 167 facilities surveyed, 26 provided data for 65 full-time permanent employees.

The staffing index shows that 65.4% of the facilities are experiencing favorable recruitment and retention conditions for this occupation. The range of conditions and percentages of facilities experiencing them are shown below:

FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
65.4%	7.7%	7.7%	19.2%

Agency-wide losses and gains were equal (17 compared to 17) for a net gain/loss rate of 0.0%. Six facilities, located in New York, New Jersey, Illinois, and Florida, reported net loss rates. The turnover rate for therapeutic radiologic technicians/technologists is 26.2%. The vacancy rate is 15.1%.

The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced and percentages are shown below:

Less than 50,000	0.0%
50,000 to 100,000	+ 1.3%
100,000 to 250,000	-30.0%
Over 250,000	+ 5.5%

There are no therapeutic radiologic technicians/technologists employed in psychiatric facilities.

Most facilities (80.8%) responded that sufficient funding and ceiling were available to achieve authorized staffing levels if candidates were available.

2. Reasons for Losses

Over 31% of therapeutic radiologic technician/technologist losses were attributed to opportunities for higher pay at the same level of responsibility. Detailed reasons for losses are as follows:

Higher pay at same level of responsibility	31.6%
Relocation	21.1%
Higher-level position with higher pay	10.5%
Retirement	10.5%
Changes of job description	5.3%
Educational reasons	5.3%
Changes occurring in Federal employment (e.g., retirement coverage, benefits, etc.)	0.0%
Different type of patient care environment	0.0%
Family reasons	0.0%
Higher-level position without higher pay	0.0%

Involuntary separation	0.0%
Private practice	0.0%
Same pay, but better fringe benefits	0.0%
Other	15.7%

3. Sources of Gains

The sources of gains and percentages are as follows:

Private sector medical facility	31.3%
Recent graduate	18.8%
Unemployment	18.8%
Other VA facility	12.5%
Non-medical employment	6.3%
Military service	0.0%
Non-VA Federal medical facility	0.0%
Other medical related employment (private practice, consultant, etc.)	0.0%
Other	12.3%

4. Private Sector Pay Comparison

Exactly 76% of the respondents stated that therapeutic radiologic technicians/technologists working in local non-Federal medical facilities receive salaries which are higher than their VA counterparts performing comparable work.

Pay differential categories and percentages are as follows:

- Much more ($4,000 per annum or more) at other facilities	44.0%
- More (up to $4,000 per annum more) at other facilities	32.0%
- Comparable	12.0%
- Less (up to $4,000 less) at other facilities	4.0%
- Much less ($4,000 per annum or more) at other facilities	8.0%

5. Pay Practices at Other Local Medical Facilities

Nearly 80% of VA facilities reported that pay practices at other medical facilities put the VA at a disadvantage in hiring and recruiting therapeutic radiologic technicians/technologists. Other reasons and percentages reported are as follows:

Regularly Scheduled General Pay Increases	79.2%
On-Call	35.0%
Weekend Premium Pay	31.8%
Holiday Shift	28.6%
Overtime	23.8%
Other	11.1%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities. Of the 15 medical districts that responded, however, facilities reported disadvantages on health benefits (81.8%) and tuition assistance (70%).

Additionally, they indicated that day care for children (30%); incentive awards (21.1%); annual leave (15.8%); retirement program (15.8%); and sick leave (10.5%) put them at a disadvantage with non-Federal medical facilities. Miscellaneous reasons were cited 11.1% of the time.

7. Necessity for Alternative Methods of Coverage

Almost 20% of facilities reported that they needed alternative methods of coverage, e.g., additional shifts, overtime on a recurring basis, the use of temporary and intermittent therapeutic radiologic technicians/technologists, etc. The Western and Southwestern Regions experienced the greatest need for using alternative methods of coverage, while the Mid-Atlantic Region had the largest percentage of other occupations providing that coverage. Regions and percentages are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	0.0	12.5
Mid-Atlantic	0.0	50.0
Southeastern	33.3	0.0
Great Lakes	16.7	16.7
Mid-Western	0.0	0.0
Western	50.0	0.0
Southwestern	50.0	0.0

8. Educational Institution Affiliations

Twenty-four percent of the responding medical facilities are affiliated with educational institutions which train therapeutic radiologic technicians/technologists. Fifty-seven students were trained annually in fiscal years 1984-86. The average number of students who accepted employment at the facilities where they were trained in fiscal years 1984-86 was three. While the ratio of hires to trainees in the medical districts ranged from 0% to 100%, high ratios generally represented low actual hires. For example, the highest rate was in a southwestern medical district which hired both of its students. Two medical districts trained 39 students and hired none.

9. Recruitment Techniques and Their Effectiveness

Newspaper advertising was the most frequently used technique with nine facilities indicating that they had used this means at least once. Three facilities reported that they had used advertising four or more times. College visits ranked second with six facilities reporting its use.

Recruitment techniques and responses are as follows:

Recruitment Techniques	Facilities Using 1-3 Times	Facilities Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Newspaper Ads	6	3	9	4
College Visits	3	3	6	3
Job Fairs	3	2	5	2
Prof. Meetings	3	2	5	0
Prof. Associations	3	1	4	1
Prof. Journals	1	0	1	1
Pamphlets	0	1	1	0

10. Special Pay Rates

Exactly 52% of the facilities that responded to this question said that they have considered requesting special pay rates.

Of the 16 facilities that responded to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund the additional cost?", one said that the decision was partly affected by the requirement, and 15 reported that the decision was not affected by the requirement.

The helpfulness of special pay rates in resolving recruitment and retention problems was assessed by seven facilities with authorizations in effect as follows:

Helpful	3
Partially helpful	0
Not helpful	4

As of October 1, 1986, 18 facilities were authorized special salary rates for therapeutic radiologic technicians/technologists, and four new requests were under consideration.

11. Applicant Responses

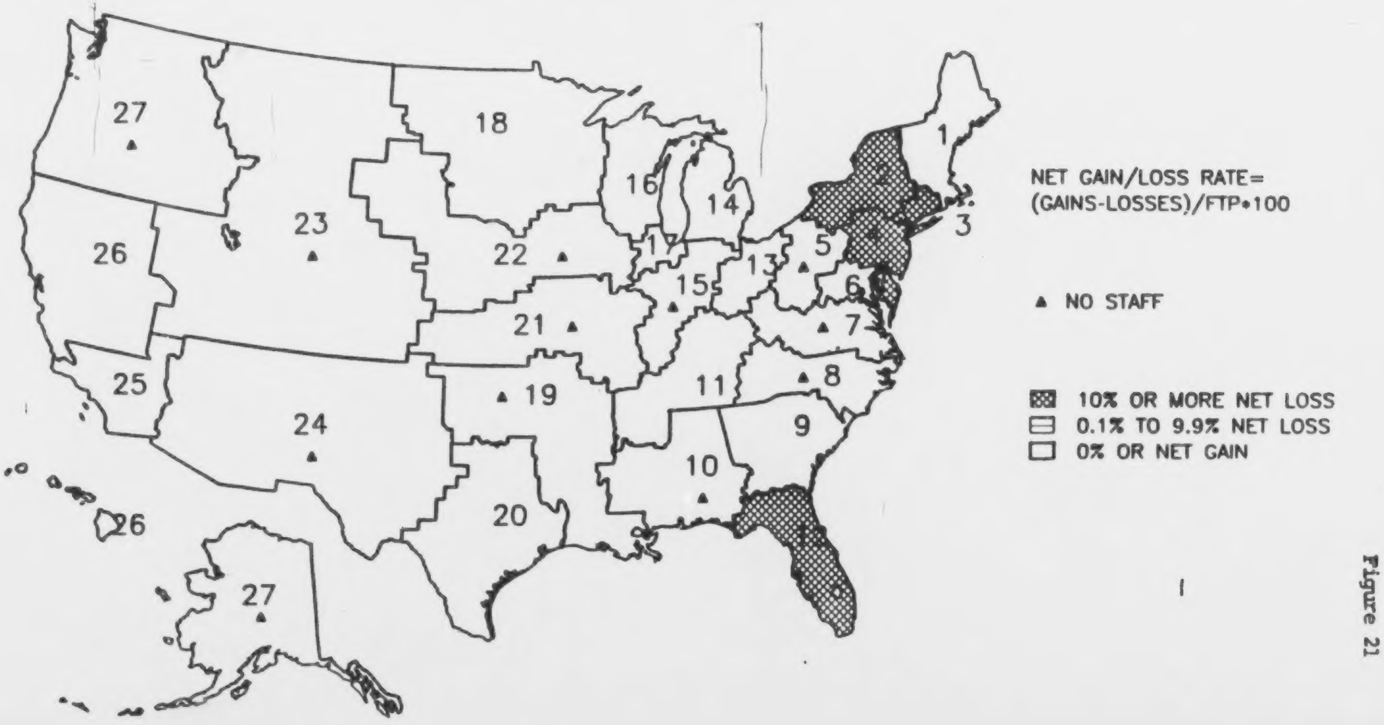
Facilities hired 24% of available applicants. Five districts were able to hire 100% of the applicants, while the same number of districts hired 20% or less. Facilities reported that 29% of the applicants were not selected for failure to meet qualification requirements and for miscellaneous reasons, including suitability and previous work records. Of the 47% of the applicants who declined employment, the reasons and percentages are as follows:

Salary	87.2%
Job Factors	8.5%
Recruitment Delays	0.0%
Working Conditions	0.0%
Other	4.3%

12. Comments

Additional comments to the survey were provided by eight facilities. Five facilities, four located in metropolitan areas and one located in a less populous area, indicated that relatively low salaries were responsible for recruitment and retention difficulties. One facility indicated that it had contracted out for technical radiology services. Another facility reported that it had used the Upward Mobility Program to fill its therapeutic radiologic position.

NET GAIN/LOSS RATE BY MEDICAL DISTRICT
FOR THERAPEUTIC RADIOLOGIC TECHNICIANS/TECHNOLOGISTS
As of October 1, 1986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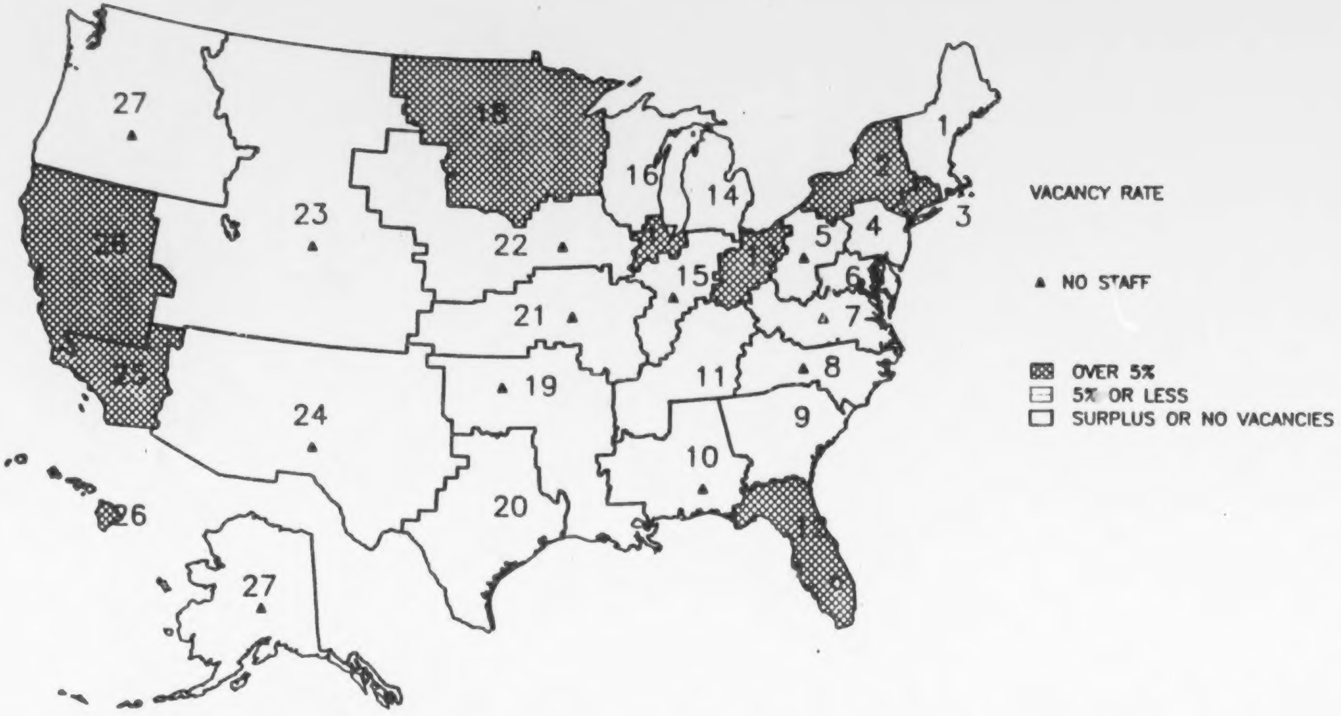
☐ 0% OR NET GAIN

Figure 21

VACANCY RATE BY MEDICAL DISTRICT
FOR THERAPEUTIC RADIOLOGIC TECHNICIANS/TECHNOLOGISTS
As of October 1, 1986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VACANCY RATE
▲ NO STAFF
▨ OVER 5%
☐ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 22

DENTAL ASSISTANT

Part A. HIGHLIGHTS

o DM&S-wide losses exceeded gains by four for a net loss rate among dental assistants of almost 0.5%. Of the 166 facilities providing data, 30 (18.1%) reported net losses. Most of these facilities are located in the northeastern states and California. Other facilities that reported losses are scattered throughout the country. Over 74% of facilities indicated that they are experiencing favorable recruitment and retention situations for dental assistants. Moderate staffing difficulties are being experienced by 6.6% of the facilities.

o Most facilities (89.4%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

o Slightly more than 10% of dental assistant losses are attributed to opportunities for higher pay at the same level of responsibility.

o More than 75% of the facilities reported that VA dental assistants earn salaries which are comparable to or greater than those earned by their counterparts working in local non-Federal medical facilities.

o Nearly 30% of the facilities reported that regularly scheduled general pay increases offered by private medical facilities placed them at a disadvantage in hiring and retaining dental assistants.

o Almost 38% of the dental assistants who decline employment with the VA cite salary as the reason.

o Federal fringe benefits generally are competitive with those provided by private sector facilities although in some locales, health insurance and tuition assistance benefits place the VA at a disadvantage.

o On the average, less than 2% of the dental assistant students trained at a VA facility are hired by the facility.

o 58% of the dental assistants who apply for VA employment are found unacceptable by the Agency.

o Relocation accounts for the largest number of dental assistant losses. Retirement accounts for the next largest number of losses.

o Nearly 50% of the dental assistants hired are recruited from private sector medical facilities or private practice.

o Less than 4% of the dental assistant new hires are recent graduates.

Part B. Analysis of Responses

1. Staffing Data

Of the 167 facilities surveyed, 166 provided data for 987 full-time permanent employees.

The staffing index shows that 74.1% of the facilities are experiencing favorable recruitment and retention conditions for dental assistants. The range of conditions and percentages of facilities experiencing them are shown below:

FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
74.1%	6.6%	10.9%	8.4%

Agency-wide losses for dental assistants exceeded gains by four employees (190 compared to 186) for a net loss rate of almost 0.4%. The turnover rate for dental assistants is 19.3%, and the vacancy rate is 2.5%. Facilities that reported net loss rates are concentrated in the northeastern states and California.

The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced and for psychiatric facilities (which typically have very large primary service areas) are shown below:

Less than 50,000	+2.8%
50,000 to 100,000	-4.5%
1000,000 to 250,000	+1.0%
Over 250,000	-1.0%
Psychiatric	0.0%

Most facilities (89.4%) responded that sufficient funding and ceiling were available to achieve authorized staffing levels if candidates were available.

2. Reasons for Losses

Facilities attributed over 10% of dental assistant losses to opportunities for higher pay at the same level of responsibility. Detailed reasons for losses are as follows:

Relocation	18.3%
Retirement	13.5%
Family reasons	10.1%
Higher pay at same level of responsibility	10.1%
Higher-level position with higher pay	8.2%
Educational reasons	5.8%
Private practice	5.8%

Involuntary separation	5.3%
Different type of patient care environment	3.8%
Same pay, but better fringe benefits	2.4%
Changes of job description	1.4%
Changes occurring in Federal employment (e.g., retirement coverage, benefits, etc.)	1.0%
Higher-level position without higher pay	0.0%
Other	14.3%

3. Sources of Gains

The sources of gains and percentages are as follows:

Other medical related employment (private practice, consultant, etc.)	30.0%
Private sector medical facility	18.9%
Other VA facility	13.7%
Non-VA Federal medical facility	11.6%
Unemployment	8.4%
Non-medical employment	5.3%
Military service	3.2%
Recent graduate	3.2%
Other	5.7%

4. Private Sector Pay Comparison

More than 75% of the respondents stated that VA dental assistants receive salaries which are comparable to or greater than those earned by dental assistants performing similar work in non-Federal medical facilities.

Pay differential categories and percentages are as follows:

- Much more ($4,000 per annum or more) at other facilities	4.8%
- More (up to $4,000 per annum more) at other facilities	19.4%
- Comparable	55.6%
- Less (up to $4,000 less) at other facilities	17.8%
- Much less ($4,000 per annum or more) at other facilities	2.4%

5. Pay Practices at Other Local Medical Facilities

Nearly 30% of VA facilities reported that pay practices at other medical facilities put the VA at a disadvantage in hiring and retaining dental assistants. Reasons cited and percentages are as follows:

Regularly Scheduled General Pay Increases	28.3%
Overtime	7.9%
Holiday Shift	7.1%
Weekend Premium Pay	4.7%
On-Call	3.2%
Other	14.8%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities. However, VA facilities reported the following disadvantages: health insurance (32.2%); tuition assistance (29.8%); day care for children (17.9%); incentive awards (11.1%); retirement programs (9.5%); annual leave (3.2%); and sick leave (3.2%). Miscellaneous reasons were cited 20% of the time.

7. Necessity for Alternative Methods of Coverage

The use of alternative methods of coverage (e.g., additional shifts, overtime on a recurring basis, the use of temporary and intermittent dental assistants, etc.) was reported by only one facility, located in the state of Washington. Two facilities (located in Indiana and Massachusetts) reported using employees in other occupations to provide coverage for dental assistants. The percentage of facilities by category in each region are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	0.0	4.2
Mid-Atlantic	0.0	0.0
Southeastern	0.0	0.0
Great Lakes	0.0	4.5
Mid-Western	0.0	0.0
Western	4.8	0.0
Southwestern	0.0	0.0

8. Educational Institution Affiliations

Over 39% of the medical facilities are affiliated with schools that provide a dental assistant curriculum and, on the average, over 750 students were trained annually in fiscal years 1984-86. The average number of students who accepted employment at the facilities where they were trained in fiscal years 1984-86 was 11. While the ratio of hires to trainees in the medical districts ranged from 0% to 10%, high ratios generally represented low actual hires. For example, the highest rate was in Oklahoma where one facility was able to hire one of its ten students. In 17 medical districts, 355 students were trained and none were hired.

9. Recruitment Techniques and Their Effectiveness

Newspaper advertising was the most frequently used technique with 26 facilities indicating that they had used advertising one to three times. Three facilities reported its use four or more times. Advertisements resulted in applications being received by 28 facilities. This was more than four times the number of the next highest source, suggesting that advertising in local newspapers is a very effective recruitment technique.

Recruitment techniques and responses are as follows:

Recruitment Techniques	Facilities Using 1-3 Times	Facilities Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Newspaper Ads	26	3	29	28
Job Fairs	13	3	16	6
Prof. Meetings	8	1	9	4
College Visits	8	1	9	3
Prof. Associations	7	1	8	3
Pamphlets	2	0	2	0
Prof. Journals	1	0	1	1

10. Special Pay Rates

More than 6% of the facilities that responded to this question said that they have considered requesting special pay rates. These facilities are located in California, Massachusetts, Minnesota, and Utah.

Of the 105 facilities that responded to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund the additional cost?", 2 indicated that the decision was completely affected by the requirement; 5 said the decision was partly affected by the requirement; and 98 reported that the decision was not affected by the requirement.

As of October 1, 1986, four facilities were authorized special pay rates for dental assistants. All of them are located in Massachusetts, and their assessment of the helpfulness of special rates is as follows:

Helpful	1
Partially helpful	3
Not helpful	0

There were no new requests under Central Office consideration as of October 1, 1986.

11. Applicant Responses

Facilities hired 25% of available applicants. Four districts were able to hire 40% or more of the applicants, while six districts hired 20% or less. Facilities reported that 58% of the applicants were not selected for failure to meet qualification requirements and for miscellaneous reasons, including suitability and previous work records. Of the 15% of the applicants who declined employment, the reasons and percentages are as follows:

Salary	37.5%
Recruitment Delays	6.3%
Job Factors	0.0%
Working Conditions	0.0%
Other	56.3%

12. Comments

Additional comments to the survey were provided by 20 facilities. Of these, eight indicated that salary and fringe benefits were primarily responsible for recruitment and retention difficulties.

Six facilities reported that they did not have difficulty in staffing dental assistant positions. Two commented that special salary rates in effect were beneficial to their recruitment and retention efforts.

The remaining comments received were primarily centered around staffing situations unique to individual facilities. One facility recommended revising and updating the current dental assistant qualification standard. Another facility expressed frustration with the applicant certification process administered by the Office of Personnel Management.

NET GAIN/LOSS RATE BY MEDICAL DISTRICT FOR DENTAL ASSISTANTS
As of October 1, 1986

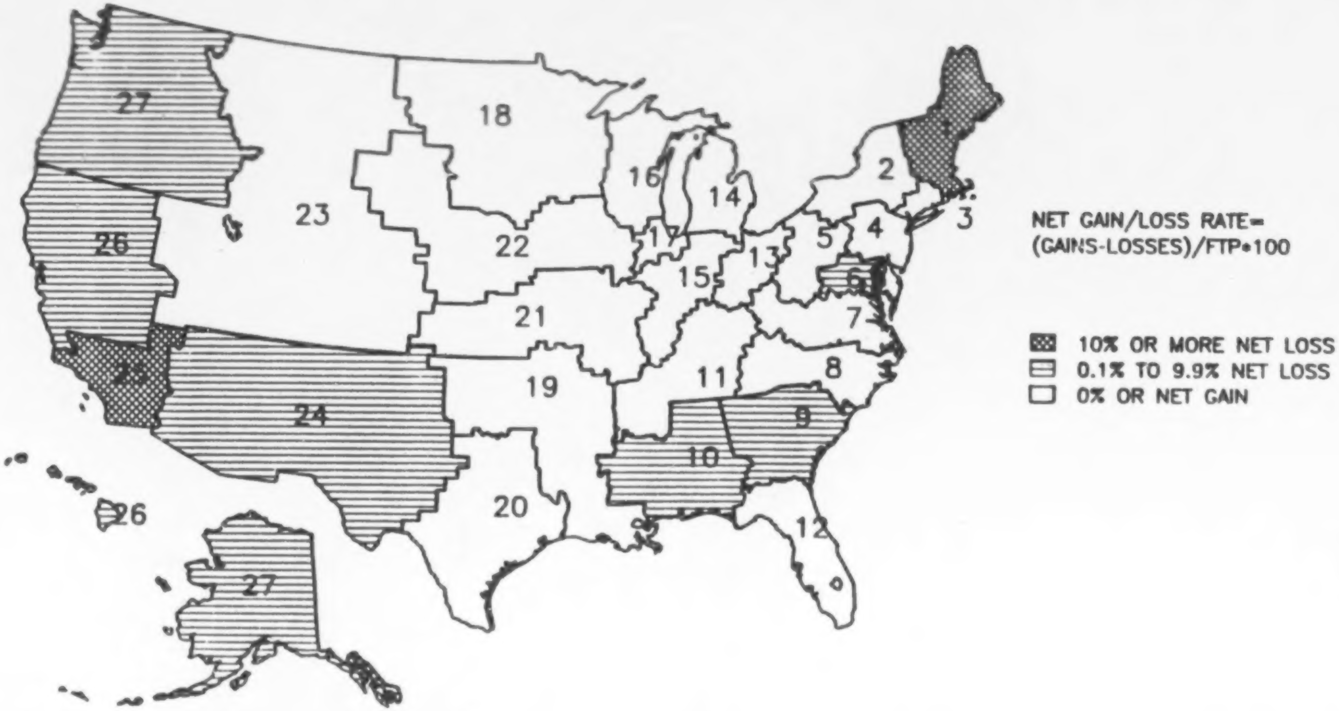
NET GAIN/LOSS RATE=
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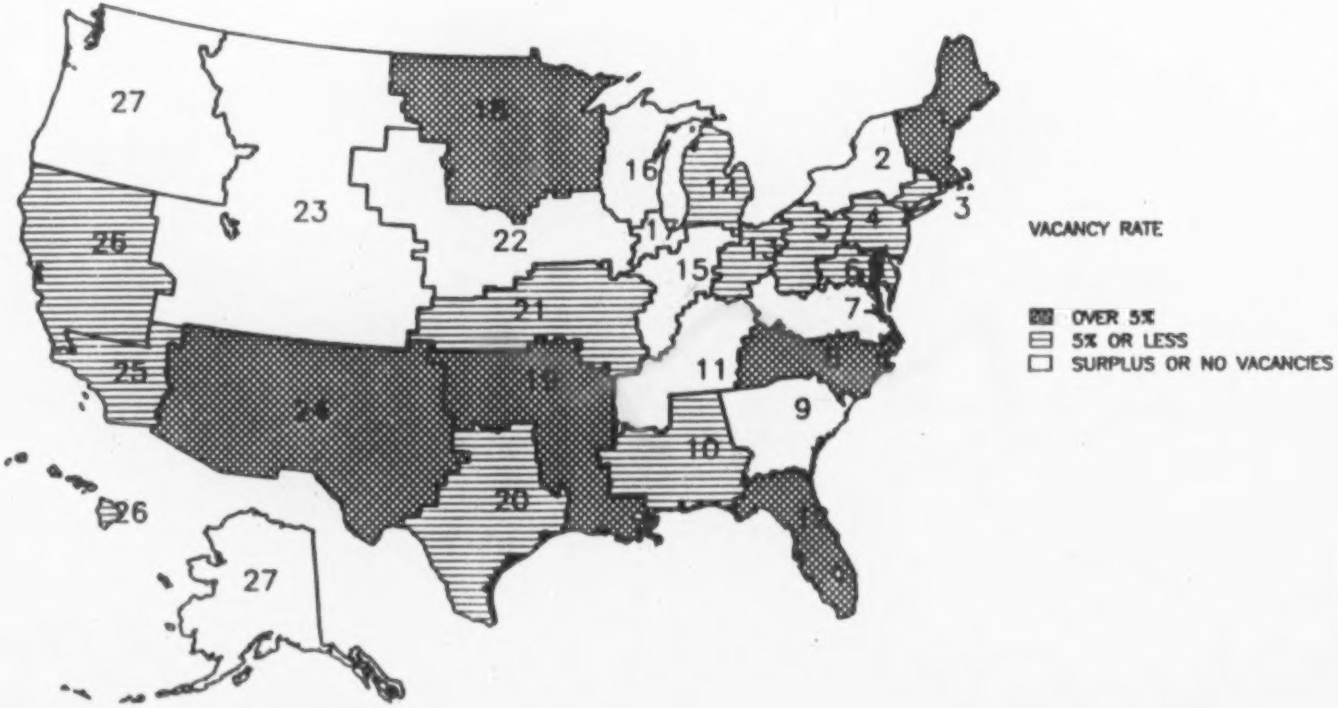
Figure 23

VACANCY RATE BY MEDICAL DISTRICT FOR DENTAL ASSISTANTS
As of October 1, 1986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VACANCY RATE
▩ OVER 5%
▤ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 24

DENTAL HYGIENIST

Part A. HIGHLIGHTS

o DM&S-wide gains for all dental hygienists exceeded losses by one for a net gain of less than 1%. Of the 138 facilities providing data on dental hygienists, 6 (or 4.5%) reported net losses. The facilities are located in Illinois, Louisiana, Pennsylvania, South Carolina, Virginia, and West Virginia. About 87.7% of the responding facilities are experiencing favorable recruitment and retention situations for dental hygienists. Moderate staffing difficulties are being experienced by 1.5% of the facilities.

o Most facilities (91.2%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

o Over 30% of dental hygienist losses are attributed to opportunities for higher pay at the same level of responsibility.

o Nearly 55% of the facilities reported that VA dental hygienists earn salaries which are less than those earned by their counterparts working in local non-Federal medical facilities.

o Almost 35% of the facilities reported that the regularly scheduled general pay increases offered by private medical facilities placed them at a disadvantage in hiring and retaining dental hygienists.

o Over 50% of the dental hygienists who decline employment with the VA cite salary as the reason.

o Federal fringe benefits generally are competitive with those provided by private sector facilities although in some locales, health insurance and tuition assistance benefits place the VA at a disadvantage.

o On the average, less than 1% of the dental hygienist students trained at a VA facility are hired by the facility.

o 46% of the dental hygienists who apply for VA employment are found unacceptable by the Agency.

o Significant numbers of dental hygienists leave their VA positions to relocate.

o Nearly 70% of those hired are recruited from private sector medical facilities and other medically related employment.

o About 5% of the dental hygienist new hires are recent graduates.

Part B. Analysis of Responses

1. Staffing Data

Of the 167 facilities surveyed, 138 provided data for 163 full-time permanent dental hygienists.

The staffing index shows that 87.7% of the facilities are experiencing favorable recruitment and retention conditions for dental hygienists. The range of conditions and percentages of facilities experiencing them are shown below:

FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
87.7%	1.5%	3.6%	7.2%

Agency-wide gains exceeded losses by 1 (36 compared to 35) for a net gain of almost 0.6%. Facilities experiencing net losses were scattered throughout the VA system. The turnover rate for dental hygienists is 21.5% and the vacancy rate is 7.2%. Facilities reporting net losses are located in Illinois, Louisiana, Pennsylvania, South Carolina, Virginia, and West Virginia.

The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced and for psychiatric facilities (which typically have very large primary service areas) are shown below:

Less than 50,000	0.0%
50,000 to 100,000	0.0%
100,000 to 250,000	-3.6%
Over 250,000	+1.4%
Psychiatric	+11.8%

Most facilities (91.2%) responded that sufficient funding and ceiling were available to achieve authorized staffing levels if candidates were available.

2. Reasons for Losses

Facilities attributed over 30% of dental hygienist losses to opportunities for higher pay at the same level of responsibility. Detailed reasons for losses are as follows:

Higher pay with same level of responsibility	30.2%
Relocation	14.0%
Family reasons	11.6%
Private practice	11.6%
Different type of patient care environment	7.0%
Higher-level position with higher pay	7.0%
Changes of job description	2.3%
Educational reasons	2.3%
Involuntary separation	2.3%
Retirement	2.3%
Changes occurring in Federal employment (e.g., retirement coverage, benefits, etc.)	0.0%
Higher-level position without higher pay	0.0%
Same pay but, better fringe benefits	0.0%
Other	9.4%

3. **Sources of Gains**

The sources of gains and percentages are as follows:

Other medical related employment (private practice, consultant, etc.)	48.7%
Other VA facility	20.5%
Private sector medical facility	20.5%
Recent graduate	5.1%
Non-medical employment	2.6%
Non-VA Federal medical facility	0.0%
Military service	0.0%
Unemployment	0.0%
Other	2.6%

4. **Private Sector Pay Comparison**

Almost 55% of the respondents stated that dental hygienists working in non-Federal medical facilities receive salaries which are higher than those earned by their VA counterparts performing comparable work.

Pay differential categories and percentages are as follows:

- Much more ($4,000 per annum or more) at other facilities	34.3%
- More (up to $4,000 per annum more) at other facilities	20.6%
- Comparable	32.4%
- Less (up to $4,000 less) at other facilities	11.8%
- Much less ($4,000 per annum or more) at other facilities	0.9%

5. **Pay Practices at Other Local Medical Facilities**

Pay practices at other medical facilities were reported by 34% of VA facilities as placing the VA at a disadvantage in recruiting and retaining dental hygienists. Reasons cited and percentages are as follows:

Regularly Scheduled General Pay Increases	34.0%
Overtime	6.6%
Holiday Shift	5.7%
Weekend Premium Pay	3.8%
On-Call	1.9%
Other	25.0%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities. However, VA facilities reported the following disadvantages: tuition assistance (25.7%); health insurance (23.6%); incentive awards (11.3%); day care for children (10.9%); retirement programs (8.7%); annual leave (3.8%); and sick leave (2.9%). Miscellaneous reasons were cited 12.3% of the time.

7. Necessity for Alternative Methods of Coverage

Eight facilities reported that they needed alternative methods of coverage (e.g., additional shifts, overtime on a recurring basis, the use of temporary and intermittent dental hygienists, etc.) to carry out the dental hygienist function. In addition, two other facilities reported using employees in other occupations to provide coverage. The percentage of facilities by category in each region are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	4.5	0.0
Mid-Atlantic	0.0	4.2
Southeastern	0.0	0.0
Great Lakes	5.9	5.6
Mid-Western	5.6	0.0
Western	20.0	0.0
Southwestern	10.5	0.0

8. Educational Institution Affiliations

Over 50% of the medical facilities are affiliated with schools of dental hygiene, and on the average, over 1,340 students were trained annually in fiscal years 1984-86. The average number of students who accepted employment at the facilities where they were trained in fiscal years 1984-86 was seven. While the ratio of hires to trainees in the medical districts ranged from 0% to 6.25%, high ratios generally represented low actual hires. For example, the highest rate was in a northwestern medical district, where two facilities in the state of Washington each hired 1 of the 32 students trained in the district. Twenty-one medical districts trained 1,062 students and none were hired.

9. Recruitment Techniques and Their Effectiveness

Newspaper advertising was the most frequently used technique with 20 of the facilities indicating that they had used this method of advertising 1-3 times, and 2 reporting its use 4 or more times. These advertisements resulted in applications being received by 16 facilities. This was approximately four times the number of the next highest source of applications, suggesting that advertising in local newspapers is a very effective recruiting technique.

Recruitment techniques and responses are as follows:

Recruitment Techniques	Facilities Using 1-3 Times	Facilities Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Newspaper Ads	20	2	22	16
College Visits	11	1	12	4
Job Fairs	7	1	8	2
Prof. Meetings	8	0	8	2
Prof. Associations	7	0	7	2
Prof. Journals	4	0	4	1
Pamphlets	1	1	2	0

10. Special Pay Rates

More than 12% of the facilities that responded to this question said that they have considered requesting special pay rates. The greatest concentration of stations considering special pay rates for dental hygienists is in New England and southern California.

Of the 87 facilities that responded to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund the additional cost?", 2 indicated that the decision was completely affected by the requirement; 3 said the decision was partly affected by the requirement; and 82 reported that the decision was not affected by the requirement.

As of October 1, 1986, 16 facilities were authorized special rates for dental hygienists and 12 assessed the helpfulness of special pay rates. The responses are as follows:

Helpful	6
Partially helpful	3
Not helpful	3

There were no new requests under Central Office consideration as of October 1, 1986.

11. Applicant Responses

Facilities hired 22% of available applicants. Five districts were able to hire 50% or more of the applicants, while 9 districts hired 20% or less. Facilities reported that 46% of the applicants were not selected for failure to meet qualification requirements and for miscellaneous reasons, including suitability and previous work records. Of the 32% of the applicants who declined employment, the reasons and percentages are as follows:

Salary	56.3%
Job Factors	3.1%
Working Conditions	3.1%
Recruitment Delays	0.0%
Other	37.5%

12. Comments

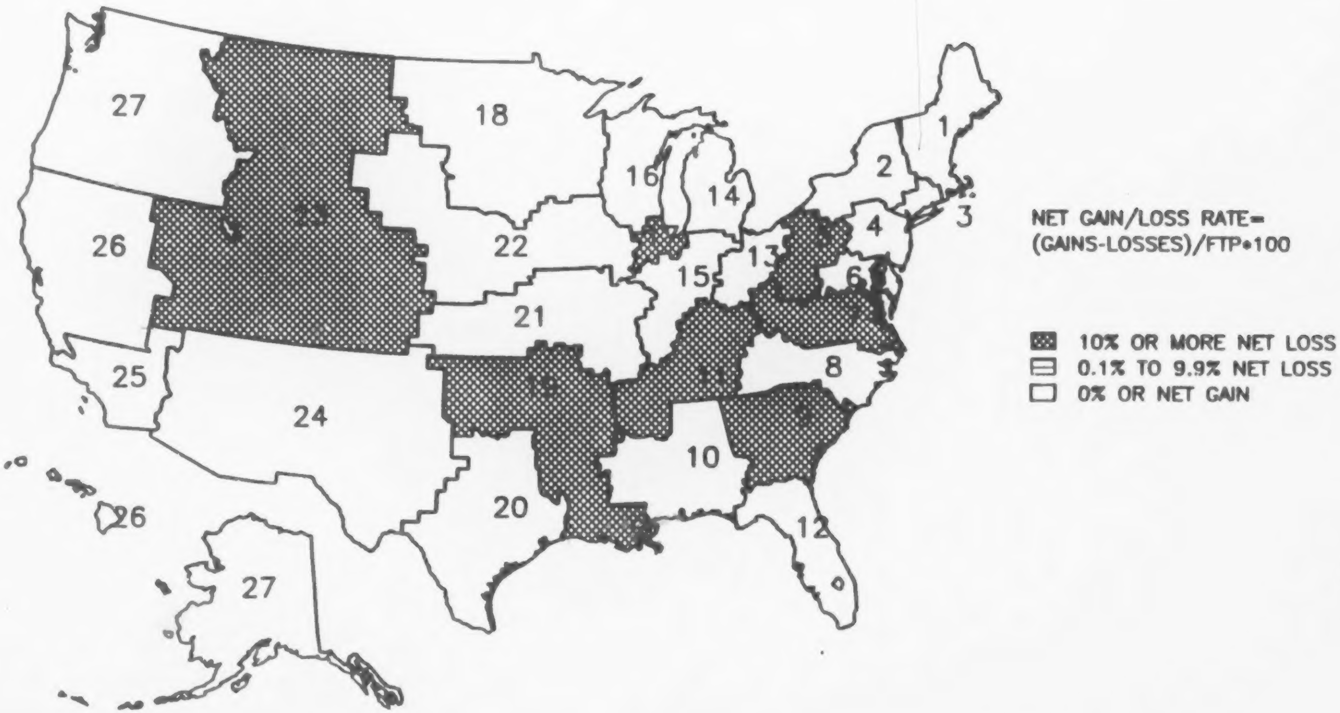
Additional comments to the survey were provided by 25 facilities. Of these, nine indicated that salary and fringe benefit programs were primarily responsible for their recruitment and retention difficulties.

Ten facilities expressed a variety of other concerns, which included impending retirements of existing staff, local staffing decisions, and school affiliation. One facility attributed difficulty in recruiting dental hygienists to local ceiling and budget limitations.

Six facilities reported that they did not have difficulty in staffing dental hygienist positions and cited on-the-job training and special salary rates as positive elements in their recruitment and retention efforts.

NET GAIN/LOSS RATE BY MEDICAL DISTRICT FOR DENTAL HYGIENISTS

As of October 1, 1986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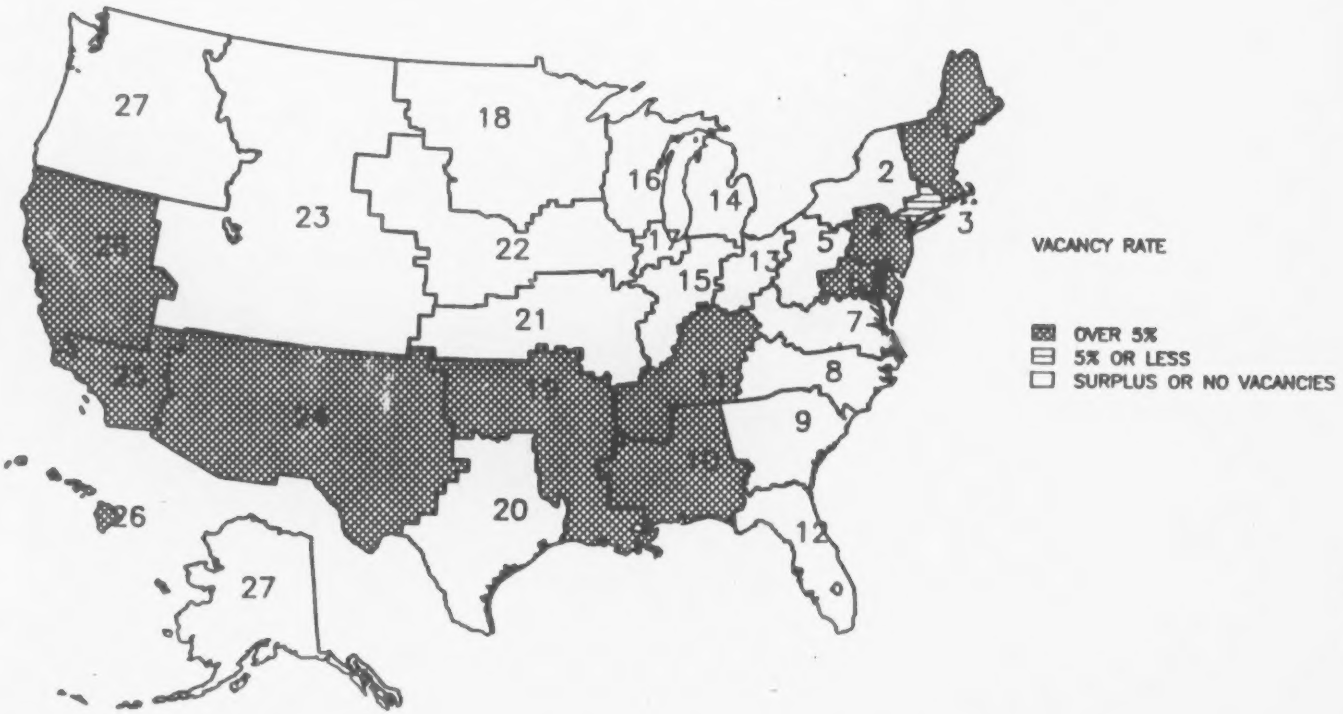
NET GAIN/LOSS RATE=
(GAINS-LOSSES)/FTP•100
▩ 10% OR MORE NET LOSS
⊟ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN

Figure 25

VACANCY RATE BY MEDICAL DISTRICT FOR DENTAL HYGIENISTS
As of October 1, 1986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VACANCY RATE
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▤ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 26

ECHOCARDIOGRAPH TECHNICIAN

Part A. HIGHLIGHTS

o DM&S-wide gains exceeded losses by two for a net gain rate of almost 2%. Of the 63 facilities providing data on echocardiograph technicians, three (4.7%) reported net losses. The three facilities which reported net losses were located in Oregon, California, and Illinois. About 90% of the reporting facilities are experiencing favorable recruitment and retention conditions.

o Most facilities (85%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

o Over 22% of echocardiograph technician losses are attributed to opportunities for higher pay at the same level of responsibility.

o Over 65% of the facilities reported that VA echocardiograph technicians earn salaries which are less than those earned by their counterparts working in local non-Federal medical facilities.

o Over 72% of the facilities reported that the regularly scheduled general pay increases offered by private medical facilities placed them at a disadvantage in hiring and retaining echocardiograph technicians.

o Nearly 90% of the echocardiograph technicians who decline employment with the VA cite salary as the reason.

o Federal fringe benefits generally are competitive with those provided by private sector facilities although in some locales, health insurance and tuition assistance benefits place the VA at a disadvantage.

o None of the students trained at VA facilities during fiscal years 1984-85 were hired by the facilities where they were trained.

o 43% of the echocardiograph technicians who apply for VA employment are found unacceptable by the Agency.

o Significant numbers of echocardiograph technicians leave their VA positions to relocate or to change their patient care environment.

o Exactly 50% of the echocardiograph technicians hired are recruited from private sector medical facilities.

o None of the new hires were recent graduates.

Part B. Analysis of Responses

1. Staffing Data

Of the 167 facilities surveyed, 63 provided data for 104 full-time permanent echocardiograph technicians.

The staffing index shows that 90.5% of the facilities are experiencing favorable recruitment and retention conditions for echocardiograph technicians. The range of conditions and percentages of facilities experiencing them are shown below:

FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
90.5%	1.6%	0.0%	7.9%

Agency-wide gains exceeded losses by two (17 compared to 15) for a net gain rate of almost 2%. The turnover rate for echocardiograph technicians is 14.4%. The vacancy rate is 3.6%. Facilities reporting net loss rates are located in Oregon, California, and Illinois.

The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced and for psychiatric facilities (which typically have very large primary service areas) are shown below:

Less than 50,000	0.0%
50,000 to 100,000	- 9.1%
100,000 to 250,000	+12.5%
Over 250,000	0.0%
Psychiatric	0.0%

Most facilities (85%) responded that sufficient funding and ceiling were available to achieve authorized staffing levels if candidates were available.

2. Reasons for Losses

Facilities attributed over 22% of echocardiograph technician losses to opportunities for higher pay at the same level of responsibiltiy. Detailed reasons for losses are as follows:

Higher pay at same level of responsibility	22.2%
Different type of patient care environment	16.7%
Relocation	16.7%
Educational reasons	11.1%
Higher-level position with higher pay	11.1%
Private practice	11.1%
Family reasons	5.6%
Changes occurring in Federal employment (e.g., retirement coverage, benefits, etc.)	0.0%
Changes of job description	0.0%

Higher-level position without higher pay	0.0%
Involuntary separation	0.0%
Retirement	0.0%
Same pay, but better fringe benefits	0.0%
Other	5.5%

3. Sources of Gains

The sources of gains and percentages are as follows:

Private sector medical facility	50.3%
Non-medical employment	11.1%
Non-VA Federal medical facility	11.1%
Other VA facility	5.6%
Unemployment	5.6%
Military service	0.0%
Other medical related employment (private practice, consultant, etc.)	0.0%
Recent graduate	0.0%
Other	16.3%

4. Private Sector Pay Comparison

Nearly 67% of the respondents stated that echocardiograph technicians working in non-Federal medical facilities receive salaries which are higher than their VA counterparts performing comparable work.

Pay differential categories and percentages are as follows:

- Much more ($4,000 per annum or more) at other facilities	29.7%
- More (up to $4,000 per annum more) at other facilities	37.0%
- Comparable	27.8%
- Less (up to $4,000 less) at other facilities	1.9%
- Much less ($4,000 per annum or more) at other facilities	3.7%

5. Pay Practices at Other Local Medical Facilities

Nearly 75% of VA facilities stated that pay practices at other medical facilities put the VA at a disadvantage in recruiting and retaining echocardiograph technicians. The reasons cited and percentages are as follows:

Regularly Scheduled General Pay Increases	72.2%
On-Call	33.3%
Overtime	25.5%
Weekend Premium Pay	16.0%
Holiday Shift	9.8%
Other	16.7%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities. However, VA facilities reported disadvantages on tuition assistance (61.7%); health insurance (61.2%); and day care for children (39.6%). (Some medical districts reported 100% on these factors.)

Additionally, facilities reported that incentive awards (29.8%); retirement programs (29.8%); annual leave (12.8%); and sick leave (6.4%) put them at a disadvantage with non-Federal medical facilities. Miscellaneous reasons were cited 16% of the time.

7. Necessity for Alternative Methods of Coverage

Almost 13% of the facilities reporting indicated that they needed alternative methods of coverage, e.g., additional shifts, overtime on a recurring basis, the use of temporary and intermittent echocardiograph technicians, etc. Eight facilities scattered across the country reported the use of alternative methods. An additional eight facilities reported using employees in other occupations to provide alternative coverage.

The percentages of facilities by category in each region are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	16.7	25.0
Mid-Atlantic	12.5	0.0
Southeastern	0.0	0.0
Great Lakes	0.0	16.7
Mid-Western	33.3	22.2
Western	10.0	10.0
Southwestern	14.3	28.6

8. Educational Institution Affiliations

Slightly more than 8% of the medical facilities are affiliated with educational institutions offering an echocardiograph technician curriculum, and, on the average, 70 students were trained annually in fiscal years 1984-86. No students accepted employment with the VA facility where they trained during this time. Only five facilities, located in New York, Florida, Virginia, and Nevada, reported training students.

9. Recruitment Techniques and Their Effectiveness

Newspaper advertising was the most frequently used technique with seven facilities indicating that they had used this means of recruiting one to three times, and one facility reporting its use four or more times. The use of professional meetings as a recruitment resource was reported by four facilities. These techniques resulted in the receipt of applications by 11 facilities.

Recruitment techniques and responses are as follows:

Recruitment Techniques	Facilities Using 1-3 Times	Facilities Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Newspaper Ads	7	1	8	7
Prof. Meetings	3	1	4	4
Prof. Associations	3	1	4	2
Prof. Journals	2	1	3	2
Job Fairs	3	0	3	2
College Visits	3	0	3	1
Pamphlets	0	0	0	0

10. Special Pay Rates

Over 8% of the facilities that responded to this question said that they have considered requesting special pay rates. These five facilities are located in New York, Virginia, and Massachusetts.

Of the 47 facilities that responded to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund that additional cost?", 3 indicated that the decision was completely affected by the requirement; 4 said the decision was partly affected by the requirement; and 40 reported that the decision was not affected by the requirement.

The helpfulness of special pay rates in resolving recruitment and retention problems was assessed by two facilities with authorizations in effect as follows:

Helpful	0
Partially helpful	0
Not Helpful	2

As of October 1, 1986, three facilities were authorized special pay rates for echocardiograph technicians, and no new requests were pending in Central Office.

11. Applicant Responses

Facilities hired 27% of available applicants. Five districts were able to hire 50% or more of the applicants, while the same number hired 20% or less.

Facilities reported that 43% of the applicants were not selected for failure to meet qualification requirements and for miscellaneous reasons, including suitability and previous work records. Of the 30% of the applicants who declined employment, the reasons and percentages are as follows:

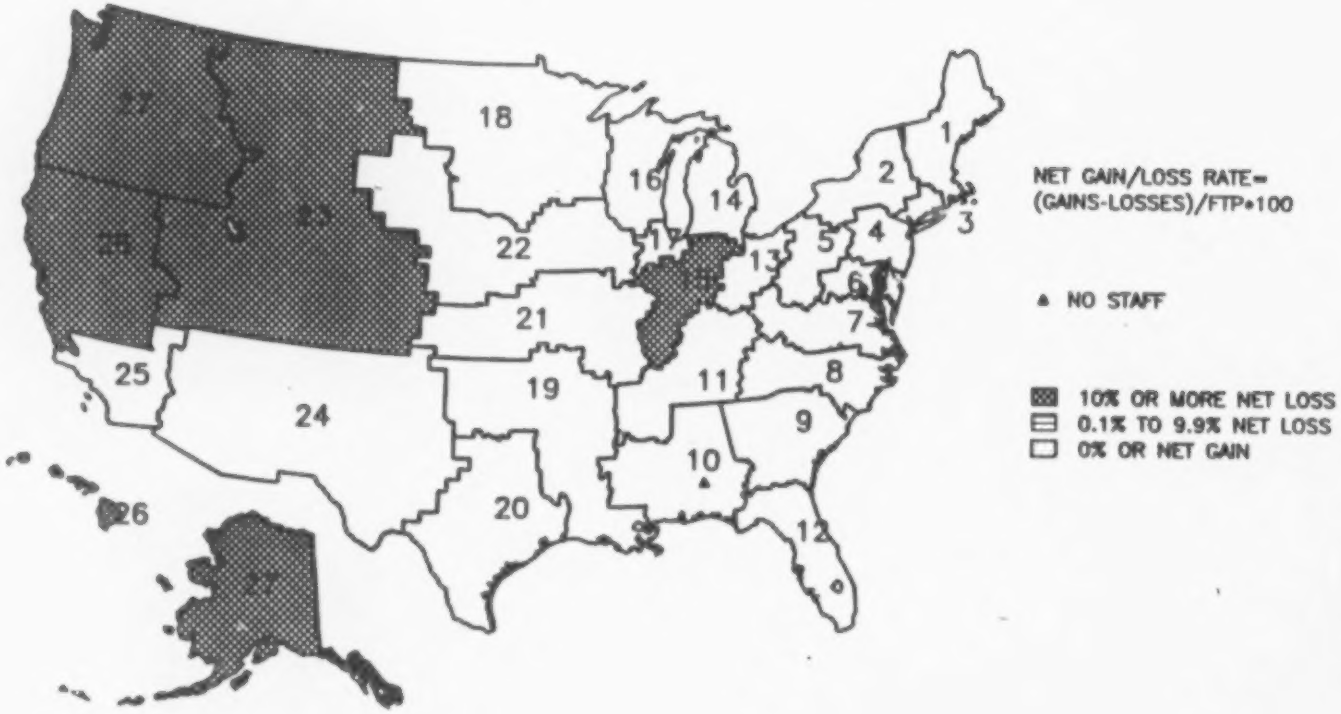
Salary	90.0%
Job Factors	0.0%
Working Conditions	0.0%
Other	10.0%

12. Comments

Additional comments to the survey were provided by 12 facilities. Of these, five indicated that salary and fringe benefit programs were primarily responsible for recruitment and retention difficulties. All of the facilities with staffing problems were located in metropolitan areas.

The remainder of the comments expressed concern about the lack of a specific classification standard for echocardiograph technician positions and explained that echocardiographic duties are being performed by either medical machine technicians or electrocardiographic technicians. One facility advocated the conversion to Title 38 as a means of improving recruitment efforts.

NET GAIN/LOSS RATE BY MEDICAL DISTRICT
FOR ECHOCARDIOGRAPH TECHNICIANS
As of October 1, 1986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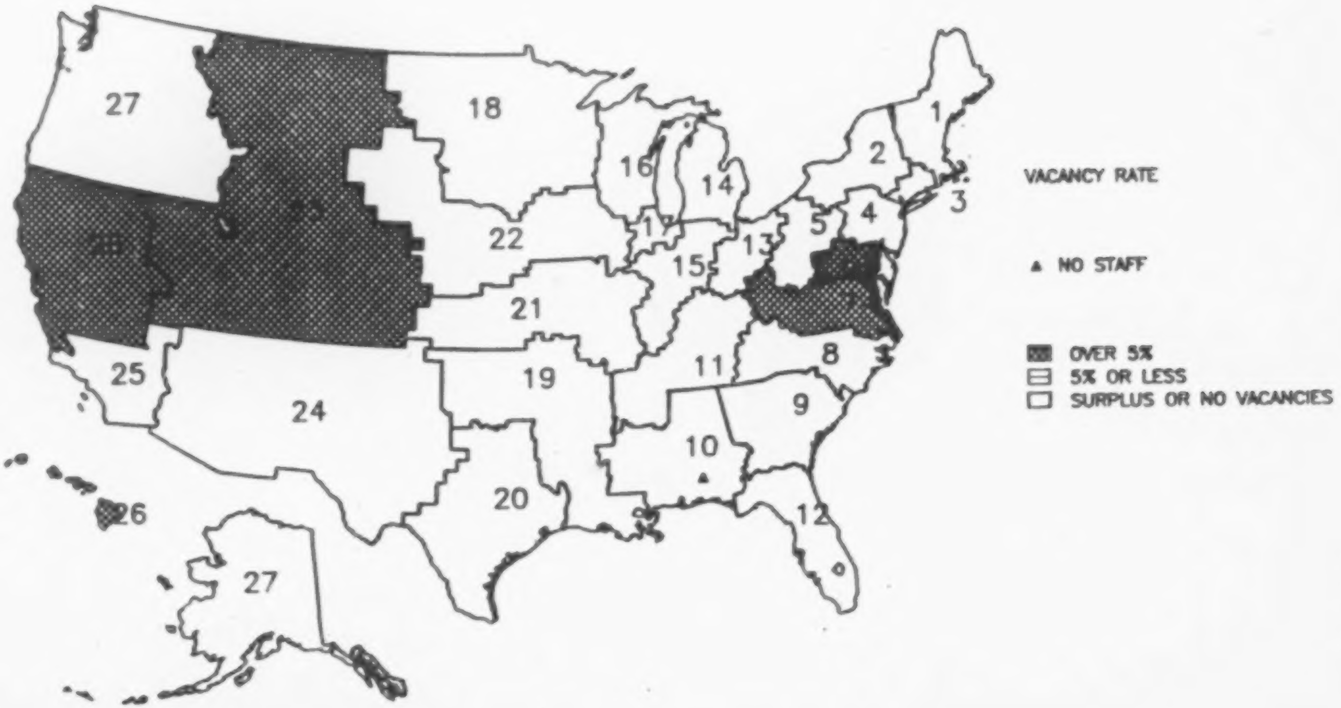
NET GAIN/LOSS RATE=
(GAINS-LOSSES)/FTP•100
▲ NO STAFF
▩ 10% OR MORE NET LOSS
⊟ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN

Figure 27

VACANCY RATE BY MEDICAL DISTRICT FOR ECHOCARDIOGRAPH TECHNICIANS

As of October 1, 1986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VACANCY RATE
▲ NO STAFF
▩ OVER 5%
▤ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 28

NUCLEAR MEDICINE TECHNICIAN

Part A. HIGHLIGHTS

o DM&S-wide losses exceeded gains by two for a net loss rate among nuclear medicine technicians of 0.8%. Of the 103 facilities providing data on nuclear medicine technicians, 9 (or 8.7%) reported net losses. About 86% of responding facilities are experiencing favorable recruitment and retention conditions for nuclear medicine technicians. Moderate staffing difficulties are being experienced by about 2.9% of the facilities.

o Most facilities (88%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

o Over 31% of nuclear medicine technician losses are attributed to opportunities for higher pay at the same level of responsibility.

o Almost 58% of the facilities reported that nuclear medicine technicians working in local non-Federal medical facilities receive higher salaries than their VA counterparts.

o Almost 52% of the facilities reported that the regularly scheduled general pay increases offered by private medical facilities placed them at a disadvantage in hiring and retaining nuclear medicine technicians.

o Over 84% of those who decline employment cite salary as the reason.

o Federal fringe benefits generally are competitive with those provided by private sector facilities although in some locales, health insurance and tuition assistance benefits place the VA at a disadvantage.

o On the average, less than 3% of the nuclear medicine technician students trained at VA facilities accept employment at the facilities where they are trained.

o 40% of those who apply for VA employment are found unacceptable by the Agency.

o Retirement accounts for over 10% of nuclear medicine technician losses.

o Nearly 43% of the nuclear medicine technicians hired are recruited from private sector medical facilities.

o Only 7% of the nuclear medicine technician new hires are recent graduates.

Part B. Analysis of Responses

1. Staffing Data

Of the 167 facilities surveyed, 103 provided data for 247 full-time permanent nuclear medicine technicians.

The staffing index shows that 86.4% of the facilities are experiencing favorable staffing conditions for nuclear medicine technicians. The range of conditions and percentages of facilities experiencing them are shown below:

FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
86.4%	2.9%	3.9%	6.8%

Agency-wide losses for nuclear medicine technicians exceeded gains by 2 employees (28 compared to 26) for a net loss rate of 0.8%. The turnover rate for nuclear medicine technicians is 11.3% and the vacancy rate is 2.7%. Facilities reporting net loss rates are located in Kentucky, Missouri, Nevada, Texas, California, Delaware, Virginia and the District of Columbia.

Losses are generally concentrated in areas of high population density. The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced and psychiatric facilities (which typically have very large primary service areas) are shown below:

Less than 50,000	+ 14.3%
50,000 to 100,000	0.0%
100,000 to 250,000	- 4.1%
Over 250,000	- 0.8%
Psychiatric	+ 11.1%

Most facilities (88%) responded that sufficient funding and ceiling were available to achieve authorized staffing levels if candidates were available.

2. Reasons for Losses

Facilities attributed over 31% of their nuclear medicine technician losses to opportunities for higher pay at the same level of responsibility. Detailed reasons for losses are as follows:

Higher pay at same level of responsibility	31.6%
Changes of job description	10.5%
Higher level position with higher pay	10.5%
Retirement	10.5%
Family reasons	7.9%
Private practice	7.9%
Different type of patient care environment	5.3%
Educational reasons	2.6%
Relocation	2.6%

Changes occurring in Federal employment (e.g., retirement coverage, benefits, etc.)	0.0%
Higher level position without higher pay	0.0%
Involuntary separation	0.0%
Same pay but better fringe benefits	0.0%
Other	10.6%

3. Sources of Gains

The sources of gains and percentages are as follows:

Private sector medical facility	42.9%
Non-VA Federal medical facility	14.3%
Recent graduate	7.1%
Military service	7.1%
Unemployment	7.1%
Other medical related employment (private practice, consultant, etc.)	3.6%
Other VA facility	0.0%
Non-medical employment	0.0%
Other	17.9%

4. Private Sector Pay Comparison

Almost 58% of the respondents stated that nuclear medicine technicians working in non-Federal medical facilities receive salaries which are higher than their VA counterparts performing comparable work.

- Much more ($4,000 per annum or more) at other favilities	15.9%
- More (up to $4,000 per annum more) at other facilities	41.5%
- Comparable	32.9%
- Less (up to $4,000 less) at other facilities	6.1%
- Much less ($4,000 per annum or more) at other facilities	3.7%

5. Pay Practices at Other Local Medical Facilities

More than half of VA facilities reported that pay practices at other medical facilities put the VA at a disadvantage in hiring and retaining nuclear medicine technicians. The pay practices cited and percentages are as follows:

Regularly Scheduled General Pay Increases	51.8%
On-Call	28.2%
Overtime	14.1%
Weekend Premium Pay	13.1%
Holiday Shift	10.7%
Other	20.9%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities. However, VA facilities reported disadvantages on tuition assistance (55.4%) and health benefits (52.2%). (Some medical districts reported 100% on both of these factors.)

Additionally, facilities reported that day care for children (32.1%); retirement programs (20.2%); incentive awards (13.4%); annual leave (7.2%); and sick leave (6.0%) put them at a disadvantage with non-Federal medical facilities. Miscellaneous reasons were cited 23.9% of the time.

7. Necessity for Alternative Methods of Coverage

Almost 10% of facilities that reported indicated that they needed alternative methods of coverage, e.g., additional shifts, overtime on a recurring basis, the use of temporary and intermittent nuclear medicine technicians, etc. Facilities in the Southeastern and Western Regions experienced the greatest need for providing alternative coverage while nationwide, only four facilities reported using employees from other occupations to meet nuclear medicine technician staffing needs. The percentage of facilities by category in each region are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	0.0	0.0
Mid-Atlantic	11.1	5.3
Southeastern	20.0	7.1
Great Lakes	0.0	0.0
Mid-Western	0.0	7.1
Western	26.7	0.0
Southwestern	8.3	8.3

8. Educational Institution Affiliations

Fifteen percent of the medical facilities are affiliated with schools of nuclear medicine and, on the average, 80 students were trained annually in fiscal years 1984-86. The average number of students who accepted employment at the facilities where they were trained in fiscal years 1984-86 was two. Facilities in the Southeastern Region trained over half of the nuclear medicine technician students.

9. Recruitment Techniques and Their Effectiveness

Newspaper advertisements were the most frequently used technique with 14 facilities indicating that they had used this means at least once. Three facilities reported that they had used advertising four or more times. Recruitment efforts through professional associations and professional meetings were also reported by ten facilities. These efforts resulted in applications being received by 17 facilities.

Recruitment techniques and responses are as follows:

Recruitment Techniques	Facilities Using 1-3 Times	Facilities Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Newspaper Ads	11	3	14	7
Prof. Associations	8	2	10	6
Prof. Meetings	9	1	10	4
Prof. Journals	5	0	5	4
Job Fairs	3	2	5	2
Pamphlets	2	0	2	1
College Visits	2	0	2	0

10. Special Pay Rates

Almost 9% of the facilities that responded to this question said that they have considered requesting special pay rates. These facilities are concentrated primarily in the Northeastern and Western Regions.

Of the 74 facilities that responded to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund that additional cost?", 2 indicated that the decision was completely affected by the requirement; 4 said the decision was partly affected by the requirement; and 68 reported that the decision was not affected by the requirement.

As of October 1, 1986, six facilities were authorized special salary rates for nuclear medicine technicians. Four facilities assessed the helpfulness of special rates as follows:

Helpful	0
Partially helpful	3
Not helpful	1

There was one new request under Central Office consideration for nuclear medicine technicians as of October 1, 1986.

11. Applicant Responses

Facilities hired 22% of available applicants. Seven districts were able to hire 100% of the applicants, while 8 districts hired 20% or less. Facilities reported that 40% of the applicants were not selected for failure to meet qualification requirements and for miscellaneous reasons, including suitability and previous work records. Of the 38% of the applicants who declined employment, the reasons and percentages are as follows:

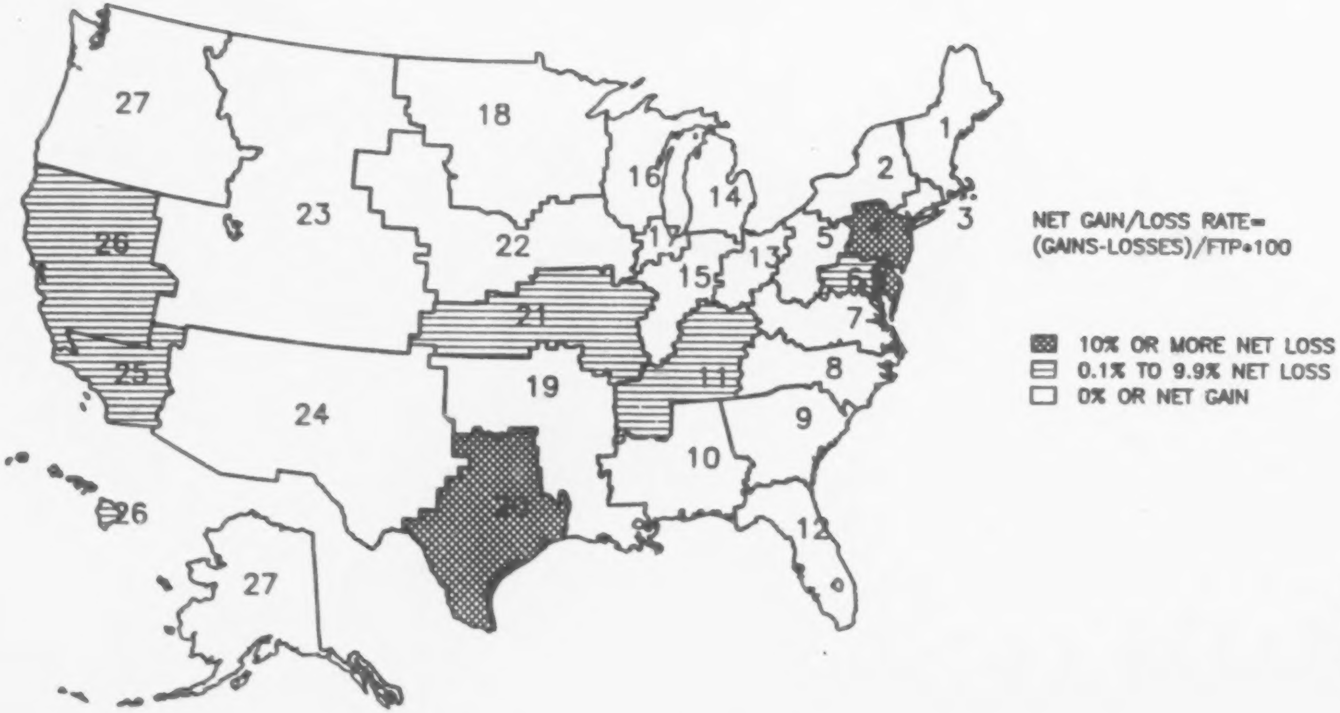
Salary	84.2%
Job Factors	5.3%
Recruitment Delays	5.3%
Working Conditions	2.6%
Other	2.7%

12. Comments

Additional comments to the survey were provided by 13 facilities. Most of the facilities expressed concerns which typically fell into two categories. Four facilities indicated that salary and fringe benefit programs were primarily responsible for their recruitment and retention difficulties. Three others reported that delays in the applicant certification process administered by OPM impedes their ability to compete for qualified nuclear medicine technicians.

Two facilities indicated that they were experiencing favorable staffing conditions in this occupation.

NET GAIN/LOSS RATE BY MEDICAL DISTRICT
FOR NUCLEAR MEDICINE TECHNICIANS
As of October 1, 1986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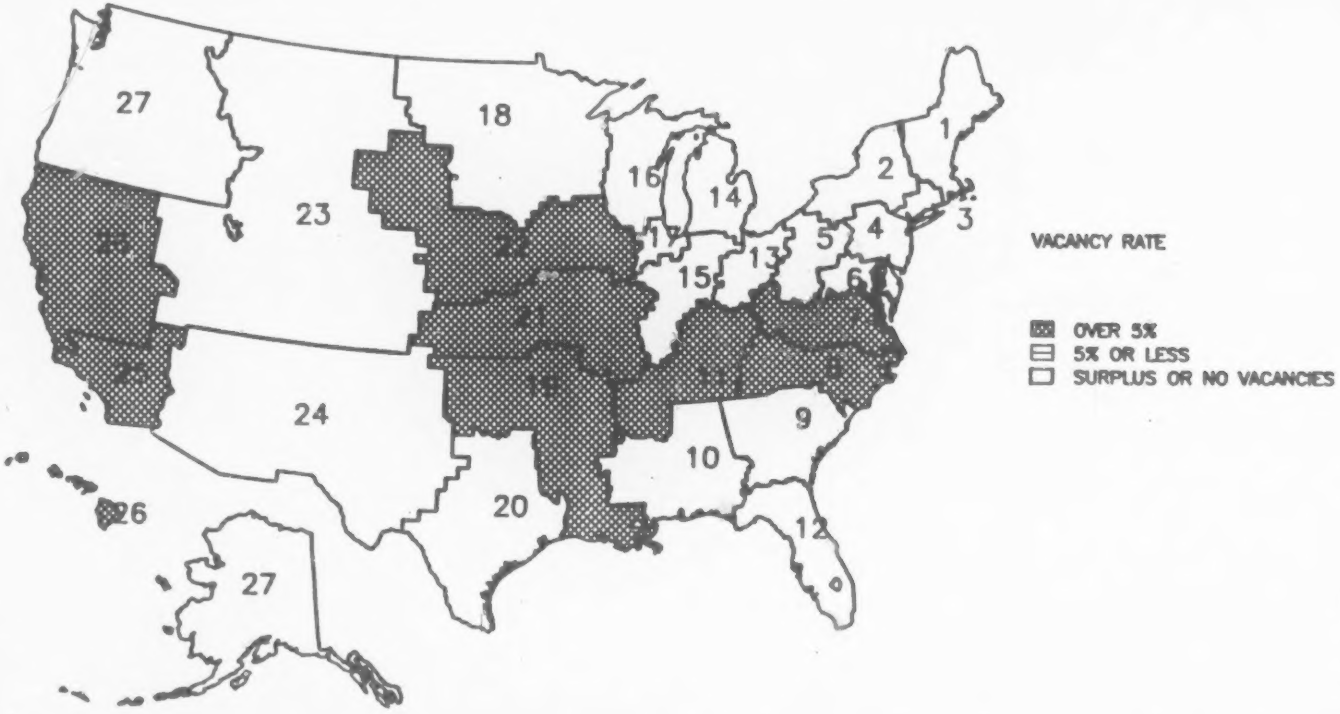
NET GAIN/LOSS RATE=
(GAINS-LOSSES)/FTP•100
▩ 10% OR MORE NET LOSS
▤ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN

Figure 29

VACANCY RATE BY MEDICAL DISTRICT FOR NUCLEAR MEDICINE TECHNICIANS

As of October 1, 1986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VACANCY RATE
▩ OVER 5%
▤ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 30

NUCLEAR MEDICINE TECHNOLOGIST

Part A. HIGHLIGHTS

o DM&S-wide gains exceeded losses by 8 for a net gain rate among nuclear medicine technologists of 3.3%. Of the 82 facilities providing data on nuclear medicine technologists, 7 (8.5%) reported net losses. These facilities are scattered across the country. About 90% of responding facilities are experiencing favorable recruitment and retention conditions. Severe staffing difficulties are being experienced by about 6% of the facilities.

o Most facilities (89%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

o 25% of nuclear medicine technologist losses are attributed to opportunities for higher pay at the same level of responsibility. Approximately 28% leave to relocate.

o Nearly 60% of the facilities reported that nuclear medicine technologists working in local non-Federal medical facilities receive higher salaries than their VA counterparts.

o Over 47% of the facilities reported that the regularly scheduled general pay increases offered by private medical facilities placed them at a disadvantage in hiring and retaining nuclear medicine technologists.

o About 61% of those who decline employment cite salary as the reason.

o Federal fringe benefits generally are competitive with those provided by private sector facilities although in some locales, health insurance and tuition assistance benefits place the VA at a disadvantage.

o Less than 6% of the nuclear medicine technologist students trained at VA facilities during fiscal years 1984-86 accepted employment in the Agency.

o 53% of those who apply for VA employment are found unacceptable by the Agency.

o Nearly 45% of the nuclear medicine technologists hired are recruited from private sector medical facilities.

o About 30% of the nuclear medicine technologist new hires are recent graduates.

Part B. Analysis of Responses

1. Staffing Data

Of the 167 facilities surveyed, 82 provided data for 240 full-time permanent nuclear medicine technologist employees.

The staffing index shows that 90.2% of the facilities are experiencing favorable conditions for nuclear medicine technologists. The range of conditions and percentages of facilities experiencing them are shown below:

FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
90.2%	3.7%	0.0%	6.1%

Agency-wide gains exceeded losses by 8 nuclear medicine technologists (36 compared to 28) for a net gain rate of 3.3%. The turnover rate for nuclear medicine technologists is 11.7% and the vacancy rate is 2.0%. The seven facilities reporting net loss rates are scattered across the country.

The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced and for psychiatric facilities (which typically have very large primary service areas) are shown below:

Less than 50,000	0.0%
50,000 to 100,000	+ 7.7%
100,000 to 250,000	+ 3.2%
Over 250,000	+ 3.3%
Psychiatric	0.0%

Most facilities (89%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

2. Reasons for Losses

Facilities attributed 25% of the nuclear medicine technologist losses to opportunities for higher pay at the same level of responsibility. Detailed reasons for losses are as follows:

Relocation	27.8%
Higher pay at same level of responsibility	25.0%
Family reasons	11.1%
Higher-level position with higher pay	8.3%
Changes of job description	5.6%
Higher-level position without higher pay	5.6%
Retirement	5.6%
Different type of patient care environment	2.8%
Private practice	2.8%
Changes occurring in Federal employment (e.g., retirement coverage, benefits, etc.)	2.7%

Involuntary separation	2.7%
Educational reasons	0.0%
Same pay, but better fringe benefits	0.0%
Other	0.0%

3. Sources of Gains

The sources of gains and percentages are as follows:

Private sector	44.4%
Recent graduate	30.6%
Non-medical employment	8.3%
Non-VA Federal medical facility	5.6%
Other VA facility	2.8%
Military service	0.0%
Other medical related employment (private practice, consultant, etc.)	0.0%
Other	8.3%

4. Private Sector Pay Comparison

Almost 60% of the respondents stated that nuclear medicine technologists working in non-Federal medical facilities receive salaries which are higher than their VA counterparts performing comparable work.

Pay differential categories and percentages are as follows:

- Much more ($4,000 per annum or more) at other facilities	19.4%
- More (up to $4,000 per annum more) at other facilities	40.3%
- Comparable	30.6%
- Less (up to $4,000 less) at other facilities	5.6%
- Much less ($4,000 per annum or more) at other facilities	4.2%

5. Pay Practices at Other Local Medical Facilities

Almost half of VA facilities reported that pay practices at other local medical facilities put the VA at a disadvantage in hiring and retaining nuclear medicine technologists. The pay practices cited and percentages are as follows:

Regularly Scheduled General Pay Increases	47.2%
On-Call	33.8%
Overtime	17.1%
Weekend Premium Pay	14.3%
Holiday Shift	11.4%
Other	17.1%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities. However, VA facilities reported disadvantages on tuition assistance (57.4%) and health benefits (54.3%). (Some medical districts reported 100% on both of these factors.)

Additionally, facilities reported that day care for children (26.1%); retirement programs (25%); incentive awards (16.2%); sick leave (5.9%); and annual leave (4.4%) put them at a disadvantage with non-Federal medical facilities. Miscellaneous reasons were cited 16.1% of the time.

7. Necessity for Alternative Methods of Coverage

Over 8% of the facilities which responded indicated that they needed alternative methods of coverage, e.g., additional shifts, overtime on a recurring basis, the use of temporary and intermittent nuclear medicine technologists, etc. Facilities in the Northeastern, Southeastern, and Great Lakes Regions reported using alternative methods of coverage while only three facilities (located in California, New York, and Utah) reported using employees in other occupations to provide coverage. The percentages of facilities by category in each region are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	14.3	7.1
Mid-Atlantic	0.0	0.0
Southeastern	25.0	0.0
Great Lakes	14.3	0.0
Mid-Western	0.0	10.0
Western	0.0	14.3
Southwestern	0.0	0.0

8. Educational Institution Affiliations

More than 30% of the VA's medical facilities are affiliated with schools of nuclear medicine and, on the average, over 180 students were trained in fiscal years 1984-86. The average number of students who accepted employment at the facilities where they were trained in fiscal years 1984-86 was 10. While the ratio of hires to trainees in the medical districts ranged from 0% to 75%, high ratios generally represented low actual hires. For example, the highest rate was at a facility in Indiana which hired three of its four students. Twelve medical districts trained 116 students and hired none.

9. Recruitment Techniques and Their Effectiveness

Newspaper advertising was the most frequently used technique with 13 facilities indicating that they had used this means of recruiting at least once. Four facilities reported that they had used advertising four or more times. These advertisements resulted in applications being received by seven facilities. Although no recruitment technique was heavily used, all except job fairs and pamphlets appeared to be reasonably effective. Six facilities reported use of job fairs with receipt of applications reported by only one. The single facility which used pamphlets four or more times received no applications.

Recruitment techniques and responses are as follows:

Recruitment Techniques	Facilities Using 1-3 Times	Facilities Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Newspaper Ads	9	4	13	7
College Visits	9	2	11	4
Prof. Meetings	8	0	8	4
Prof. Associations	7	0	7	4
Prof. Journals	6	0	6	5
Job Fairs	5	1	6	1
Pamphlets	0	1	1	0

10. Special Pay Rates

Almost 9% of the facilities that responded to this question said that they have considered requesting special pay rates. These facilities are concentrated primarily in the Northeastern Region.

Of the 56 facilities that responded to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund the additional cost?", 2 indicated that the decision was completely affected by the requirement; 2 said the decision was partly affected by the requirement; and 52 reported that the decision was not affected by the requirement.

As of October 1, 1986, four facilities were authorized special rates for nuclear medicine technologists. These four facilities assessed the helpfulness of special rates as follows:

Helpful	0
Partially Helpful	3
Not Helpful	1

There were two new requests for special salary rates for nuclear medicine technologists under Central Office consideration as of October 1, 1986.

11. Applicant Responses

Facilities hired 17% of available applicants. Five districts were able to hire 50% or more of the applicants, while 9 districts hired 20% or less. Facilities reported that 53% of the applicants were not selected for failure to meet qualification requirements and for miscellaneous reasons, including suitability and previous work records. Of the 31% of the applicants who declined employment, the reasons and percentages are as follows:

Salary	61.2%
Job Factors	9.7%
Recruitment Delays	9.7%
Working Conditions	3.2%
Other	16.3%

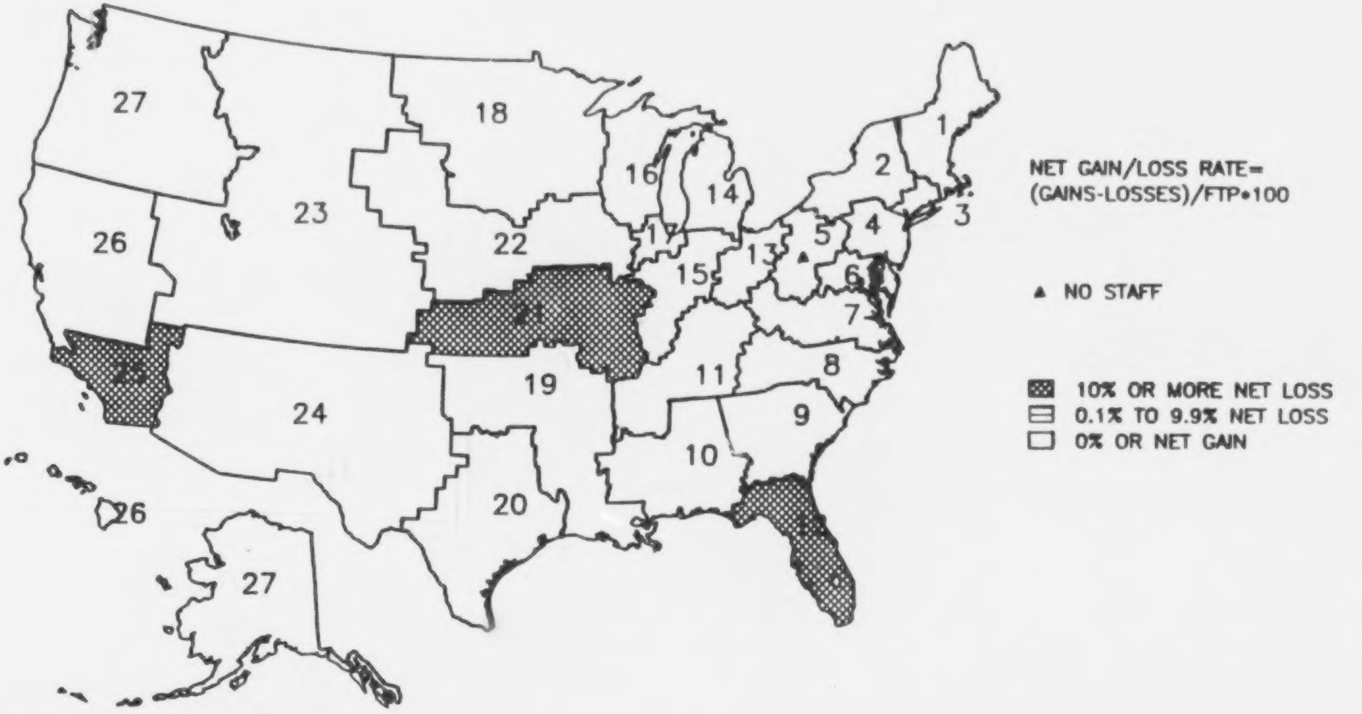
12. Comments

Additional comments to the survey were provided by 20 facilities. Of these, three indicated that favorable staffing conditions were present in their locations.

Four facilities reported that salary and fringe benefit programs were primarily responsible for their recruitment and retention difficulties. The remainder of the comments expressed concerns about delays in the applicant certification process administered by OPM; conservative grade-level criteria specified in the classification standard; and the lack of VA-funded continuing education.

NET GAIN/LOSS RATE BY MEDICAL DISTRICT FOR NUCLEAR MEDICINE TECHNOLOGISTS

As of October 1, 1986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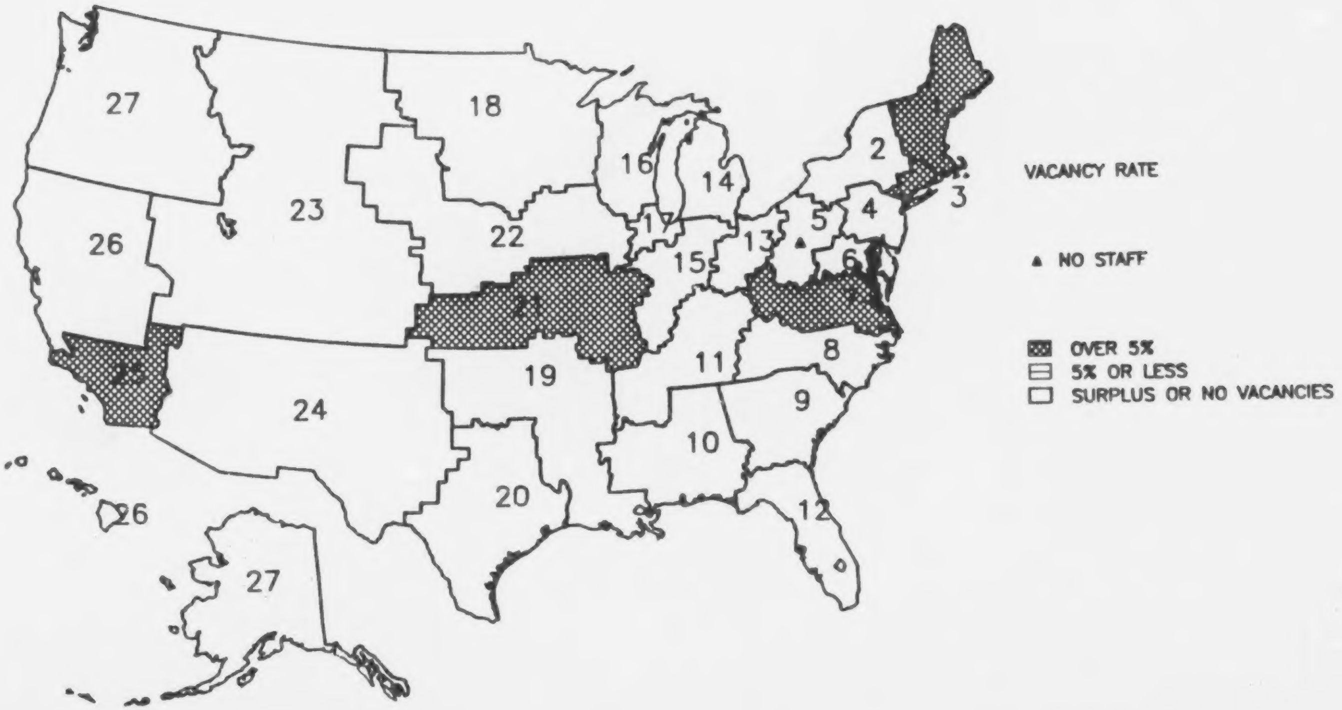
NET GAIN/LOSS RATE=
(GAINS-LOSSES)/FTP•100
▲ NO STAFF
▩ 10% OR MORE NET LOSS
⊟ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN

Figure 31

VACANCY RATE BY MEDICAL DISTRICT FOR NUCLEAR MEDICINE TECHNOLOGISTS
As of October 1, 1986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VACANCY RATE
▲ NO STAFF
▩ OVER 5%
⊟ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 32

OPHTHALMOLOGIST TECHNICIAN

Part A. HIGHLIGHTS

o DM&S-wide gains equaled losses for ophthalmologist technicians (14 to 14). Of the 50 facilities providing data on ophthalmologist technicians, 2 (or 4.0%) reported net losses. The facilities reporting net losses are in Connecticut and Texas. About 86% of the facilities report a favorable recruitment and retention situation. Severe staffing difficulties are being experienced by 14% of the facilities.

o Most facilities (93.5%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

o Over 14% of opthalmologist technician losses are attributed to opportunities for higher pay at the same level of responsibility.

o About 71% of the facilities reported that VA ophthalmologist technicians earn salaries which are comparable to or greater than those earned by their counterparts working in local non-Federal medical facilities.

o Over 40% of the facilities reported that the regularly scheduled general pay increases offered by private medical facilities placed them at a disadvantage in hiring and retaining ophthalmologist technicians.

o Of the ophthalmologist technician applicants who declined VA employment, 16% declined because of salary.

o Federal fringe benefits generally are competitive with those provided by private sector facilities although in some locales, health insurance and tuition assistance benefits place the VA at a disadvantage.

o None of the ophthalmologist technician students trained at VA facilities during fiscal years 1984-86 were hired by the facilities where they were trained.

o 80% of the ophthalmologist technicians who apply for VA employment are found unacceptable by the Agency.

o Over 14% of ophthalmologist technicians leave their VA positions to retire.

o About 17% of the opthalmologist technicians hired are recruited from private sector medical facilities.

o Over 10% of the ophthalmologist technician new hires are recent graduates.

Part B. Analysis of Responses

1. Staffing Data

Of the 167 facilities surveyed, 50 provided data for 56 full-time permanent ophthalmologist technicians.

The staffing index shows that 86% of the facilities are experiencing favorable recruitment and retention conditions for this occupation. The range of conditions and percentages of facilities experiencing them are shown below:

FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
86.0%	0.0%	0.0%	14.0%

Agency-wide gains equaled losses for ophthalmologist technicians (14 compared to 14). The turnover rate for ophthalmologist technicians is 15.0% and the vacancy rate is 11.0%. Medical facilities which reported net losses are in Connecticut and Texas.

The relatively few gains and losses in this comparatively small occupation were evenly distributed with respect to population density. No net gains or net losses were reported for medical and surgical facilities categorized by size of veteran population serviced (less than 50,000; 50,000 to 100,000; 100,000 to 250,000; and over 250,000), and for psychiatric facilities (which typically have very large primary service areas).

Most facilities (93.5%) responded that sufficient funding and ceiling were available to achieve authorized staffing levels if candidates were available.

2. Reasons for Losses

Facilities attributed over 14% of ophthalmologist technician losses to opportunities for higher pay at the same level of responsibility. Detailed reasons for losses are as follows:

Higher pay with same level of responsibility	14.6%
Retirement	14.6%
Different type of patient care environment	9.8%
Educational reasons	7.3%
Private practice	7.3%
Relocation	7.3%
Involuntary separation	7.3%
Changes occurring in Federal employment (e.g., retirement coverage, benefits, etc.)	4.9%
Changes of job description	4.9%

Family reasons	4.9%
Higher-level position with higher pay	4.9%
Higher-level position without higher pay	4.9%
Same pay, but better fringe benefits	4.9%
Other	2.4%

3. **Sources of Gains**

The sources of gains and percentages are as follows:

Private sector medical facility	17.2%
Other medical related employment (private practice, consultant, etc.)	17.2%
Non-VA Federal medical facility	10.3%
Recent graduate	10.3%
Non-medical employment	10.3%
Other VA facility	6.9%
Military service	6.9%
Unemployment	3.4%
Other	17.5%

4. **Private Sector Pay Comparison**

More than half (54.3%) of the respondents stated that salaries for VA ophthalmologist technicians are comparable to those earned by their counterparts performing similar work in non-Federal medical facilities.

Pay differential categories and percentages are as follows:

- Much more ($4,000 per annum or more) at other facilities	17.1%
- More (up to $4,000 per annum more) at other facilities	11.4%
- Comparable	54.3%
- Less (up to $4,000 less) at other facilities	8.6%
- Much less ($4,000 per annum or more) at other facilitis	8.6%

5. **Pay Practices at Other Local Medical Facilities**

About 40% of VA facilities reported that pay practices at other medical facilities put the VA at a disadvantage in hiring and retaining ophthalmologist technicians. The pay practices and percentages are as follows:

Regularly Scheduled General Pay Increases	40.5%
On-Call	8.6%
Overtime	8.6%
Weekend Premiun Pay	5.7%
Holiday Shift	2.9%
Other	10.5%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities. However, VA facilities reported disadvantages on tuition assistance (25.7%) and health benefits (20%). (Some medical districts reported 100% on both factors; others reported 100% on one of these factors.)

Additionally, facilities reported that day care for children (12.1%); retirement programs (9.1%); annual leave (5.9%); and incentive awards (5.7%) put them at a disadvantage with non-Federal medical facilities. Miscellaneous reasons were cited less than 7% of the time. No medical district reported a disadvantage on sick leave.

7. Necessity For Alternative Methods Of Coverage

Five facilities reported that they needed alternative methods of coverage, e.g., additional shifts, overtime on a recurring basis, the use of temporary and intermittent ophthalmologist technicians, etc. Three facilities, including two of those that needed alternative methods of coverage, reported using employees in other occupations as ophthalmologist technicians. The percentage of facilities by category in each region are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	25.0	0.0
Mid-Atlantic	0.0	0.0
Southeastern	7.7	7.7
Great Lakes	0.0	0.0
Mid-Western	33.3	14.3
Western	16.7	0.0
Southwestern	0.0	9.1

8. Educational Institution Affiliations

Slightly more than 6% of the medical facilities are affiliated with educational institutions which offer an ophthalmologist technician curriculum, and, on the average, 14 students were trained annually in fiscal years 1984-86. Only two facilities reported having trainees during fiscal years 1984-86. None of the students accepted employment at the facilities where they were trained during that time.

9. Recruitment Techniques and Their Effectiveness

Job fairs were the most frequently used technique. Four facilities indicated that they had used this means one to three times; one facility reported its use four or more times. Although no recruitment technique was heavily used, all except professional journals and pamphlets appeared to be reasonably effective. Two facilities reported the use of professional journals and pamphlets with no resulting receipt of applications.

Recruitment techniques and responses are as follows:

Recruitment Techniques	Facilities Using 1-3 Times	Facilities Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Job Fairs	4	1	5	1
Prof. Meetings	4	0	4	2
Newspaper Ads	3	1	4	2
Prof. Associations	3	0	3	2
College Visits	2	1	3	1
Prof. Journals	2	0	2	0
Pamphlets	2	0	2	0

10. Special Pay Rates

Only one facility (located in Alabama) reported that it has considered requesting special pay rates.

Of the 33 facilities that responded to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund the additional cost?", 1 indicated that the decision was completely affected by the requirement; 1 said the decision was partly affected by the requirement; and 31 reported that the decision was not affected by the requirement.

As of October 1, 1986, no facilities were authorized special pay rates for ophthalmologist technician, and there were no requests under Central Office consideration.

11. Applicant Responses

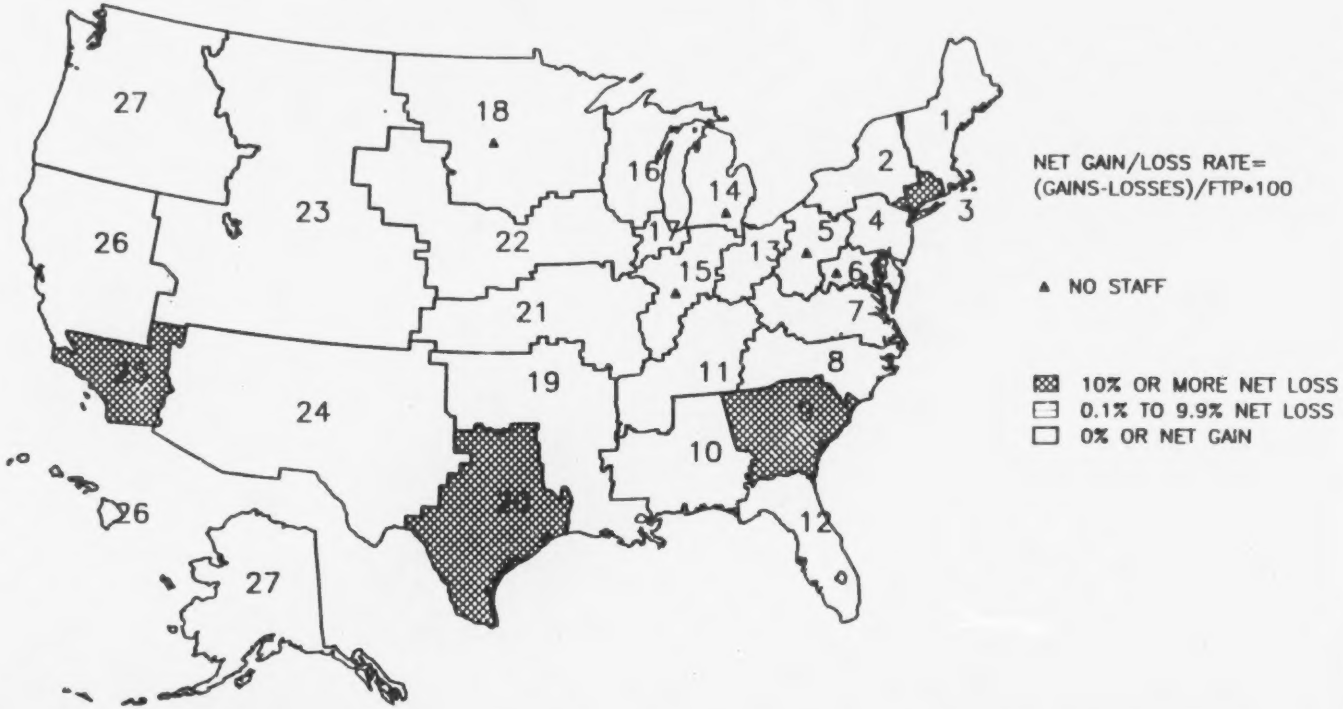
Facilities hired 14% of available applicants. Three districts were able to hire 50% or more applicants, while six districts hired 14% or less. Facilities reported that 80% of the applicants were not selected for failure to meet qualification requirements and for miscellaneous reasons, including suitability and previous work records. Of the 6% of the applicants who declined employment, the reasons and percentages are as follows:

Salary	16.6%
Job Factors	0.0%
Working Conditions	0.0%
Other	83.4%

12. Comments

Additional comments to the survey were provided by five facilities. Three of the comments expressed concern that there is no specific classification standard for the occupation, rather it is covered by the "catchall" Health Technician (GS-699) standard. Two of the facilities reported that its ophthalmologist technician positions are normally filled through the Upward Mobility Program.

NET GAIN/LOSS RATE BY MEDICAL DISTRICT
FOR OPHTHALMOLOGIST TECHNICIANS
As of October 1, 1986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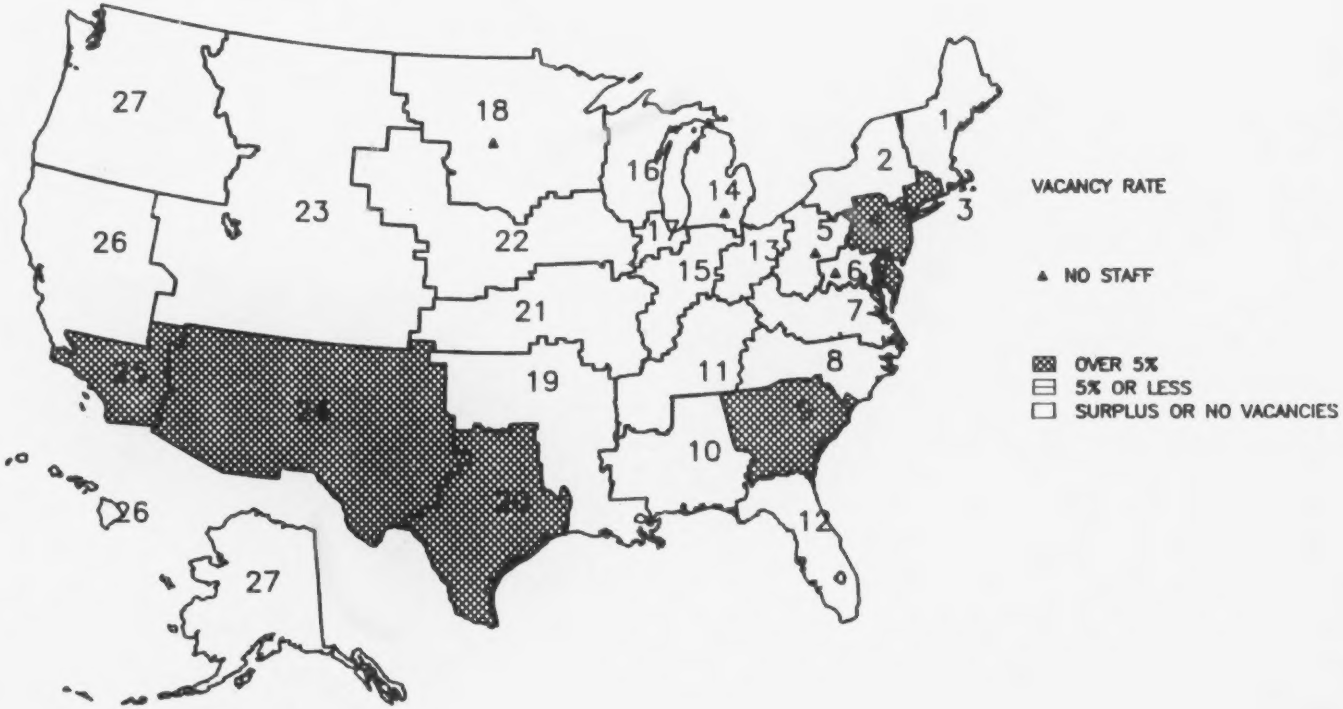
NET GAIN/LOSS RATE=
(GAINS-LOSSES)/FTP•100
▲ NO STAFF
▩ 10% OR MORE NET LOSS
▤ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN

Figure 33

VACANCY RATE BY MEDICAL DISTRICT
FOR OPHTHALMOLOGIST TECHNICIANS
As of October 1, 1986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VACANCY RATE
▲ NO STAFF
▩ OVER 5%
⊟ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 34

PULMONARY FUNCTION TECHNICIAN

Part A. HIGHLIGHTS

o DM&S-wide losses exceeded gains by two for a net loss rate among pulmonary function technicians of 2%. Of the 100 facilities that provided data on pulmonary function technicians, four reported net losses. These facilities are located in Florida, California, Missouri, and New York. Favorable recruitment and retention situations for pulmonary function technicians were reported by 92% of the responding facilities. Moderate staffing difficulties are being experienced by 3% of the facilities.

o Most facilities (89.5%) responded that sufficient funding and ceiling were available to provide authorized staffing levels if candidates were available.

o Only 6.7% of pulmonary function technician losses are attributed to opportunities for higher pay at the same level of responsibility.

o About 57% of the facilities reported that VA pulmonary function technicians earn salaries which are comparable to or greater than those earned by their counterparts working in local non-Federal medical facilities.

o Over 51% of the facilities reported that regularly scheduled general pay increases offered by private medical facilities place them at a disadvantage in hiring and retaining pulmonary function technicians.

o 100% of the pulmonary function technician applicants who declined VA employment did so because of salary.

o Federal fringe benefits generally are competitive with those provided by private sector facilities although in some locales, health insurance and tuition assistance benefits place the VA at a disadvantage.

o None of the pulmonary function technician students trained at VA facilities were hired by the facilities where they were trained during fiscal years 1984-86.

o 37% of the pulmonary function technicians who apply for VA employment are found unacceptable by the Agency.

o Over 43% of the pulmonary function technician losses are attributed to VA employees entering private practice.

o Over 38% of the pulmonary function technicians hired are recruited from private sector medical facilities.

o None of the pulmonary function technician new hires are recent graduates.

Part B. Analysis of Responses

1. Staffing Data

Of the 167 facilities surveyed, 100 provided data for 197 full-time permanent pulmonary function technicians.

The staffing index shows that 92% of the facilities are experiencing favorable recruitment and retention conditions for pulmonary function technicians. The range of conditions and percentages of facilities experiencing them are shown below:

FAVORABLE	MODERATE DIFFICULTY	SERIOUS DIFFICULTY	SEVERE DIFFICULTY
92.0%	3.0%	0.0%	5.0%

Agency-wide losses exceeded gains by four pulmonary function technicians (17 compared to 13) for a net loss rate of 2%. The turnover rate of pulmonary function technicians is 8.6%. The vacancy rate is 1.9%. Facilities reporting net loss rates are in Florida, California, Missouri, and New York.

The net gain (+) or loss (-) rates for medical and surgical facilities categorized by size of veteran population serviced and for psychiatric facilities (which typically have a very large primary service area) are shown below:

Less than 50,000	0.0%
50,000 to 100,000	0.0%
100,000 to 250,000	+ 3.2%
Over 250,000	- 5.5%
Psychiatric	-16.7%

Most facilities (89.5%) responded that sufficient funding and ceiling were available to achieve authorized staffing levels if candidates were available.

2. Reasons for Losses

Facilities attributed only 6.7% of pulmonary function technician losses to opportunities for higher pay at the same level of responsibility; one-half of these losses were to private sector practice. Detailed reasons for losses are as follows:

Private practice	43.3%
Retirement	20.0%
Higher level position with higher pay	10.0%
Family reasons	6.7%
Higher pay at same level of responsibility	6.7%
Different type of patient care environment	3.3%
Educational reasons	3.3%

Changes to job description	0.0%
Changes occurring in Federal employment (e.g., retirement coverage, benefits, etc)	0.0%
Higher-level position without higher pay	0.0%
Involuntary separation	0.0%
Relocation	0.0%
Same pay, but better fringe benefits	0.0%
Other	6.7%

3. Sources of Gaines

The sources of gains and percentages are as follows:

Private sector medical facility	38.5%
Non-medical employment	7.7%
Non-VA Federal medical facility	7.7%
Other VA facility	7.7%
Military service	0.0%
Other medical related employment (private practice, consultant, etc.)	0.0%
Recent graduate	0.0%
Unemployment	0.0%
Other	38.4%

4. Private Sector Pay Comparison

About 57% of the respondents stated that salaries for VA pulmonary function technicians are comparable to or greater than those earned by their counterparts performing similar work in non-Federal medical facilities.

Pay differential categories and percentages are as follows:

- Much more ($4,000 per annum or more) at other facilities	23.3%
- More (up to $4,000 per annum more) at other facilities	19.2%
- Comparable	49.3%
- Less (up to $4,000 less) at other facilities	6.9%
- Much less ($4,000 per annum or more) at other facilities	1.4%

5. Pay Practices at Other Local Medical Facilities

Nearly 52% of VA facilities reported that pay practices at other medical facilities put the VA at a disadvantage in hiring and retaining pulmonary function technicians. Other reasons and percentages reported are as follows:

Regularly Scheduled General Pay Increases	51.4%
On-Call	11.6%

Weekend Premium Pay	10.1%
Overtime	8.7%
Holiday Shift	2.9%
Other	6.7%

6. Fringe Benefits

Generally, facilities did not find that Federal fringe benefits put them at a disadvantage in competition with other medical facilities. However, VA facilities reported disadvantages on health benefits (52%) and tuition assistance (48.5%). (Some medical districts reported 100% on both of these factors.)

Additionally, facilities reported that retirement programs (23.2%); day care for children (17.6%); incentive awards (10.1%); annual leave (7.4%); and sick leave (4.4%) put them at a disadvantage with non-Federal medical facilities. Miscellaneous reasons were cited 21.9% of the time.

7. Necessity for Alternative Methods of Coverage

Six facilities indicated that they needed alternative methods of coverage, e.g., additional shifts, overtime on a recurring basis, the use of temporary and intermittent pulmonary function technicians, etc. Five facilities reported using employees in other occupations to provide coverage for pulmonary function technicians. The percentage of facilities by category in each region are as follows:

Region	Percent Using Alternative Methods of Coverage	Percent Employing Other Occupations
Northeastern	7.1	0.0
Mid-Atlantic	5.9	5.6
Southeastern	0.0	0.0
Great Lakes	0.0	16.7
Mid-Western	7.1	14.3
Western	14.3	0.0
Southwestern	7.7	0.0

8. Educational Institution Affiliations

Over 16% of the VA's medical facilities are affiliated with educational institutions offering a pulmonary function technician curriculum. On the average, over 140 students were trained annually in fiscal years 1984-86. During fiscal years 1984-86, 15 VA facilities, scattered throughout the country, served as training sites. None of the students accepted employment at the VA facilities where they were trained during this time period.

9. Recruitment Techniques and Their Effectiveness

Newspaper advertising was the most frequently used technique with five facilities indicating that they had used this means one to three times. Advertisements resulted in applications being received by four facilities. Three facilities reported receiving applications generated from professional meetings and professional associations.

Recruitment techniques and responses are as follows:

Recruitment Techniques	Facilities Using 1-3 Times	Facilities Using 4+ Times	Total Facilities Using	Facilities Receiving Applications
Newspaper Ads	5	0	5	4
Prof. Meetings	3	1	4	1
Prof. Associations	2	1	3	2
Job Fairs	0	1	1	0
Prof. Journals	1	0	1	0
College Visits	1	0	1	0
Pamphlets	0	0	0	0

10. Special Pay Rates

Slightly more than 3% of the facilities that responded to this question said that they have considered requesting special pay rates. Only three facilities (two located in southern California and one located in Nevada) reported that they have considered requesting special pay rates.

Of the 69 facilities that responded to the question, "If special rates have not been requested, to what extent was that decision affected by the requirement that the facility fund the additional cost?", 4 indicated that the decision was completely affected by the requirement; 3 said the decision was partly affected by the requirement; and 62 reported that the decision was not affected by the requirement.

As of October 1, 1986, no facilities were authorized special salary rates for pulmonary function technicians, and no requests were under Central Office consideration.

11. Applicant Responses

Facilties hired 41% of available applicants. Five districts were able to hire 100% of the applicants, while seven districts hired 33% or less. Facilities reported that 37% of the applicants were not selected for miscellaneous reasons, including suitability and previous work records. Of the 24% of the applicants who declined employment, all gave salary as the reason.

12. Comments

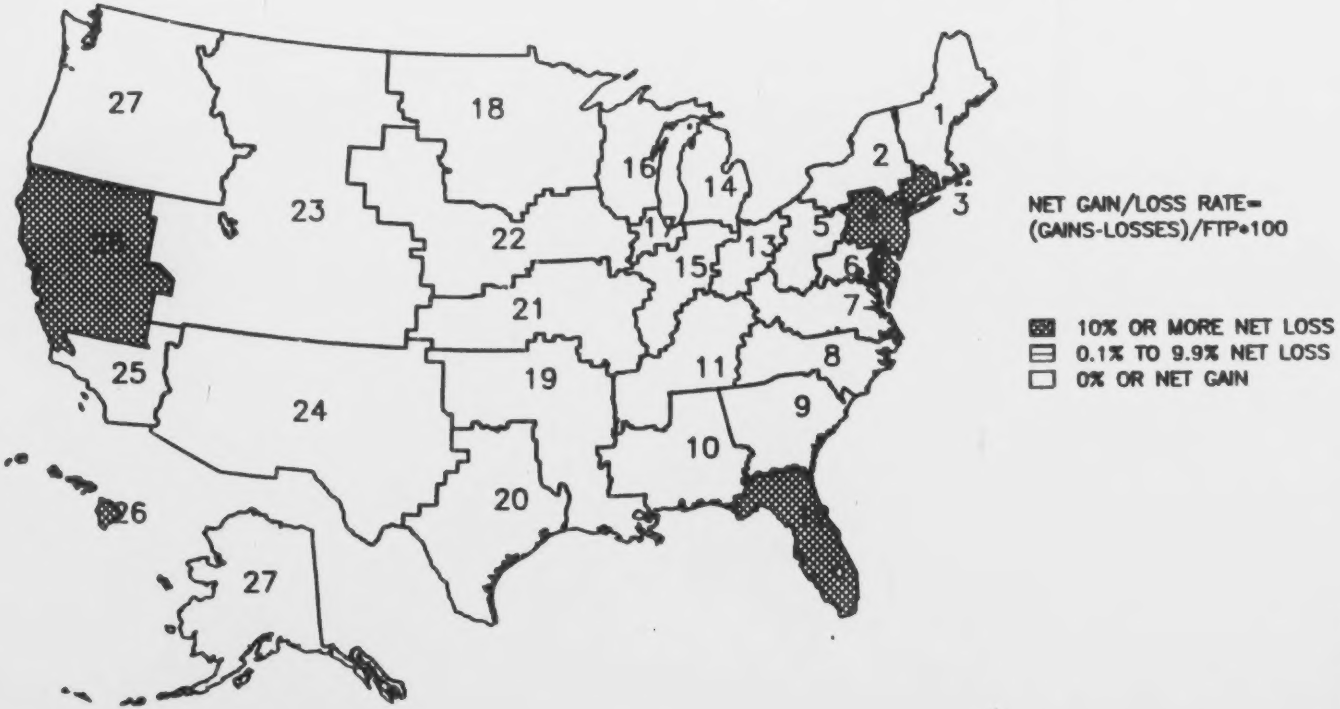
Additional comments to the survey were received from 14 facilities. Of these, five reported favorable staffing situations for pulmonary function technicians.

Five facilities expressed concerns that the present classification standard utilized for pulmonary function technicians (GS-649, Medical Machine Technician) does not adequately reflect the complexities of the occupation.

Other concerns expressed by facilities related to inadequate salaries, delays in the Office of Personnel Management applicant certification process, and the need for a professional credentialing examination. One facility recommended conversion to Title 38.

NET GAIN/LOSS RATE BY MEDICAL DISTRICT FOR PULMONARY FUNCTION TECHNICIANS

As of October 1, 1986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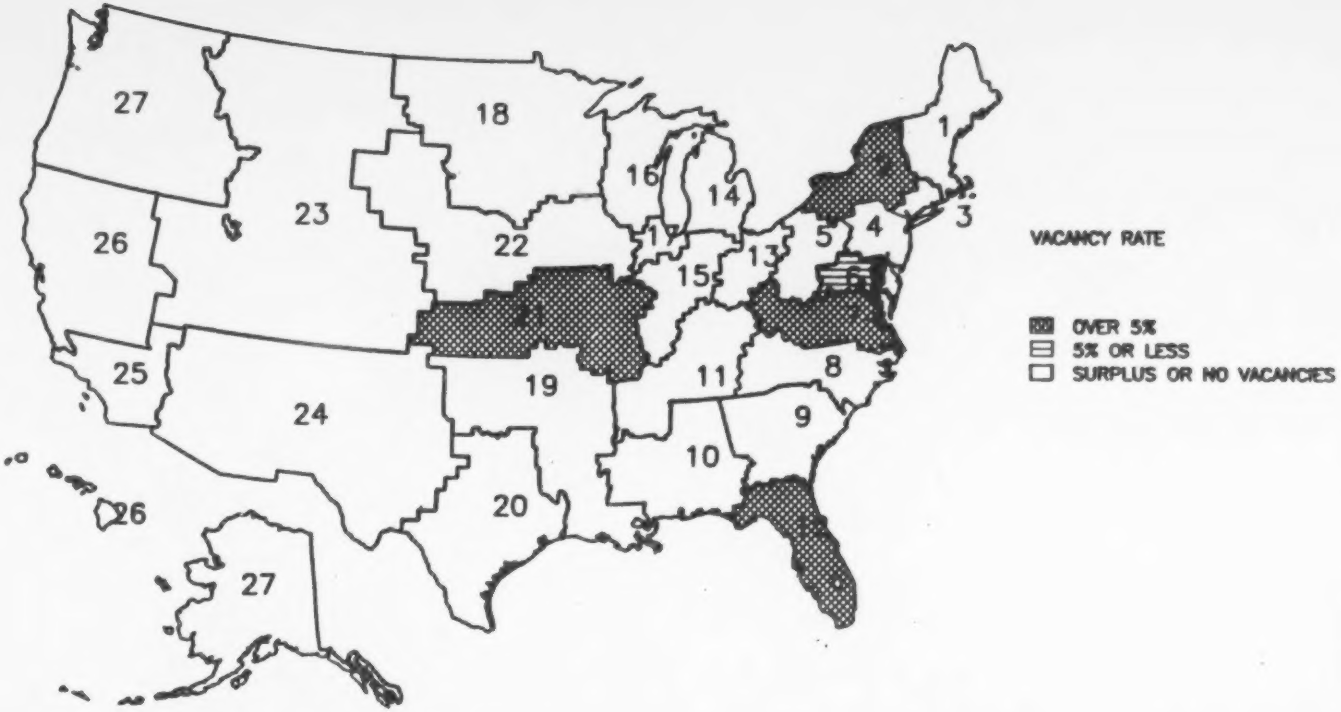
NET GAIN/LOSS RATE=
(GAINS-LOSSES)/FTP*100
▩ 10% OR MORE NET LOSS
▤ 0.1% TO 9.9% NET LOSS
☐ 0% OR NET GAIN

Figure 35

VACANCY RATE BY MEDICAL DISTRICT FOR PULMONARY FUNCTION TECHNICIANS

As of October 1, 1986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VACANCY RATE
▩ OVER 5%
☰ 5% OR LESS
☐ SURPLUS OR NO VACANCIES

Figure 36

APPENDIX A

Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420

CIRCULAR 10-86-134
December 5, 1986

TO: Regional Directors, Directors, VA Medical Center Activities (111/05)

SUBJECT: 1986 Survey of Health Occupational Staff (RCS 10-86-22)

1. PURPOSE: The purpose of this circular is to collect data to assess recruitment and retention trends among several VA health occupations: Dental Assistants, Dental Hygienists, Diagnostic and Therapeutic Radiologic Technicians, Echocardiograph Technicians, Nuclear Medicine Technicians, Nuclear Medicine Technologists, Occupational Therapists, Ophthalmologist Technicians, Pharmacists, Physical Therapists, Pulmonary Function Technicians, Certified/Registered Respiratory Therapists, Registered Nurses, Licensed Practical/Vocational Nurses, and Nursing Assistants. The data obtained will be used for planning and other purposes by Agency officials who must address the Department's health care personnel needs. This circular is a temporary issue and will not be incorporated into permanent publications.

2. POLICY: Data for the survey will be collected on two forms, Attachments A and B. VA Form 10-20826A(NR) covers most of the health occupations to be surveyed. A separate copy must be completed for each occupation listed on this form. VA Form 10-20826B(NR) covers data for Nursing Service only. Only one copy of this form should be submitted since its questions have been formatted to allow separate responses for each of the occupational areas covered. Additional copies of the forms should be obtained through local reproduction as necessary. Every facility will provide data for each of the identified occupations, even if there is just one authorized position in a particular occupation. Facilities will be provided summary information about the results of the survey.

3. ACTION: The Medical Center Director will designate a responsible official to serve as the facility's overall survey coordinator. The Chief of Staff and Personnel Officer should participate in completing the survey, since input from both of their offices is essential. Carefully follow the instructions in Attachment C for completing the survey forms to assure that all items are correctly completed. The person(s) completing each form should sign it in the space provided at the end of the form. In the event that questions arise concerning the data on a form, the person signing the form may be contacted. The completed survey forms should be forwarded to VACO, Recruitment and Examining Division (054E). This report is due in VACO by December 19, 1986. Questions concerning this circular should be referred to Bernard Palmer or Terry Young, FTS 233-3257.

4. REFERENCE: None

5. RESCISSION: This DM&S Circular will expire December 19, 1986.

6. FOLLOW-UP RESPONSIBILITY: Director, Personnel and Labor Relations (054E).

John A Gronvall
JOHN A. GRONVALL, M.D.
Acting Chief Medical Director

Attachments

Distribution: COA: (10) only
SS (054) FLD: RD, MA-1
plus 200-2
EX: Boxes 44-C & 49-2, Boxes 104, 60, 54, 52- each & 63-5

THIS CIRCULAR EXPIRES ON DECEMBER 19, 1986

Attachment A

CIRCULAR 10-86-134

HEALTH OCCUPATIONS SURVEY
(RCS 10-86-22)

Facility No. 2 3 4 ☐☐☐

1. Enter the code of the occupation for which this form is being completed:

1 = Dental Assistant
2 = Dental Hygienist
3 = Diagnostic Radiologic Technician/Technologist
4 = Therapeutic Radiologic Technician/Technologist
5 = Echocardiograph Technician
6 = Nuclear Medicine Technician
7 = Nuclear Medicine Technologist
8 = Occupational Therapist
9 = Ophthalmologist Technician
10 = Pharmacist
11 = Physical Therapist
12 = Pulmonary Function Technician
13 = Certified/Registered Respiratory Therapist

5 6 ☐☐

2. (a1) Number of staff on duty as of October 1, 1986: FTP .... 7 8 9 ☐☐☐

(a2) Other .... 10 11 12 13 14 15 ☐☐☐☐.☐☐

(b) Number of authorized FTEE .... 16 17 18 19 20 21 ☐☐☐☐.☐☐

(c1) Number of full-time staff having less than 1 year of service .... 22 23 24 ☐☐☐

(c2) Less than 3 years of service .... 25 26 27 ☐☐☐

(d) Number of full-time staff gains during FY '86 .... 28 29 30 ☐☐☐

(e) Number of full-time staff losses during FY '86 .... 31 32 33 ☐☐☐

3. Are sufficient funding and ceiling available to provide authorized staffing level if candidates are available?

1 = Yes
2 = No

34 ☐

4. How many of the full-time losses between October 1, 1985 and September 30, 1986 left for the following reasons?

(a) Higher pay for the same assignment level .... 35 36 37 ☐☐☐

(b) Higher level position with higher pay .... 38 39 40 ☐☐☐

(c) Higher level position without higher pay .... 41 42 43 ☐☐☐

(d) Same pay but better fringe benefits .... 44 45 46 ☐☐☐

(e) Educational reasons .... 47 48 49 ☐☐☐

CIRCULAR 10-86-134
Facility No. ____
Occupation ____

4. (f) Private practice .... 50 51 52 ☐☐☐

(g) Family reasons .... 53 54 55 ☐☐☐

(h) Different type of patient care environment .... 56 57 58 ☐☐☐

(i) Relocation .... 59 60 61 ☐☐☐

(j) Retirement .... 62 63 64 ☐☐☐

(k) Involuntary separation .... 65 66 67 ☐☐☐

(l) Changes of job description .... 68 69 70 ☐☐☐

(m) Changes occurring in Federal employment (e.g., retirement coverage, benefits, etc.) .... 71 72 73 ☐☐☐

(n) Other (please specify) ____________________ 74 75 76 ☐☐☐

____

____

5. How many of the full-time gains between October 1, 1985 and September 30, 1986 were most recently employed in the following situations?

(a) Other VA facility .... 77 78 79 ☐☐☐

(b) Non-VA Federal medical facility .... 80 81 82 ☐☐☐

(c) Private sector medical facility .... 83 84 85 ☐☐☐

(d) Other medical related employment (private practice, consultant, etc.) .... 86 87 88 ☐☐☐

(e) Recent graduate .... 89 90 91 ☐☐☐

(f) Non-medical employment .... 92 93 94 ☐☐☐

(g) Military service .... 95 96 97 ☐☐☐

(h) Unemployment .... 98 99 100 ☐☐☐

CIRCULAR 10-86-134
Facility No. ______
Occupation ______

5. (i) Other (please specify) ____________________ 101 ☐ 102 ☐ 103 ☐

____

____

6. (a) Has this occupation lost any FTEE in the past 3 years to other occupations because of your difficulty in recruiting applicants?

1 = Yes
2 = No
104 ☐

(b) If yes, how many? .... 105 ☐ 106 ☐ 107 ☐ 108 ☐ . 109 ☐ 11

7. How comparable to VA pay is the average pay at the journeyman level at non-Federal medical facilities in your area?

1 = Much more ($4,000 per annum or more) at other facilities
2 = More (up to $4,000 per annum more) at other facilities
3 = Comparable
4 = Less (up to $4,000 less) at other facilities
5 = Much less ($4,000 per annum or more) at other facilities
6 = Don't know
111 ☐

8. Do any of the following pay practices for this occupation at other medical facilities in your area put the VA at a disadvantage?

1 = Yes
2 = No

(a) Regular pay increases .... 112 ☐

(b) Overtime .... 113 ☐

(c) Holiday shift .... 114 ☐

(d) Weekend premium pay .... 115 ☐

(e) On-call .... 116 ☐

(f) Other (please specify) ____________________ 117 ☐

____

____

9. Do any of the following "fringe" benefits or packages for this occupation at other medical facilities put the VA at disadvantage?

1 = Yes
2 = No

(a) Health insurance .... 118 ☐

(b) Tuition assistance .... 119 ☐

(c) Incentive award program .... 120 ☐

CIRCULAR 10-86-134
Facility No. ___
Occupation ___

9. (d) Retirement program .... 121 ☐

(e) Day care for children .... 122 ☐

(f) Vacation or personal leave time .... 123 ☐

(g) Sick leave .... 124 ☐

(h) Other (please specify) ____________________ 125 ☐

____

____

10. Have alternative methods of coverage (e.g., additional shifts, contracting out, etc.) been necessary?

1 = Yes
2 = No
126 ☐

11. (a) Have you employed individuals from other occupations to meet the staffing needs of this function?

1 = Yes
2 = No
127 ☐

(b) If so, please identify the types of other occupations or technicians and the number employed.

Type of other occupation ____________________ 128 ☐ 129 ☐

Number employed .... 130 ☐ 131 ☐ 132 ☐

Type of other occupation ____________________ 133 ☐ 134 ☐

Number employed .... 135 ☐ 136 ☐ 137 ☐

Type of other occupation ____________________ 138 ☐ 139 ☐

Number employed .... 140 ☐ 141 ☐ 142 ☐

12. (a) Are you affiliated with educational institutions to provide training in this field?

1 = Yes
2 = No
143 ☐

(b) If so, how many students have been trained annually in this occupation at your facility (average number for FY '84, '85, and '86)? .... 144 ☐ 145 ☐ 146 ☐

(c) How many former students trained at your facility in this occupation were hired at your facility during FY '86? .... 147 ☐ 148 ☐ 149 ☐

CIRCULAR 10-86-134
Facility No. ____
Occupation ____

13. How frequently, if at all, were the following recruitment techniques utilized during the past fiscal year?

1 = Not Used
2 = Used 1-3 Times
3 = Used 4 or More Times

(a) Newspaper ads .... 150 ☐

(b) Professional journals .... 151 ☐

(c) College visits .... 152 ☐

(d) Pamphlets .... 153 ☐

(e) Job fairs .... 154 ☐

(f) Professional meetings or conferences .... 155 ☐

(g) Professional associations .... 156 ☐

14. How effective were these techniques?

1 = No applications from this sources
2 = 1-5 applications received
3 = More than 5 applications received

(a) Newspaper ads .... 157 ☐

(b) Professional journals .... 158 ☐

(c) College visits .... 159 ☐

(d) Pamphlets .... 160 ☐

(e) Job fairs .... 161 ☐

(f) Professional meetings or conferences .... 162 ☐

(g) Professional associations .... 163 ☐

15. What was the number of applications received during the past fiscal year

From OPM (including SEU's)? .... 164 ☐ 165 ☐ 166 ☐

From all other sources? .... 167 ☐ 168 ☐ 169 ☐

VA FORM 10-20826A(NR)
DEC 1986

)

CIRCULAR 10-86-134
Facility No. ____
Occupation ____

16. Of the applications received, how many persons

(a) Were subsequently employed by your facility? .... 170 171 172 ☐☐☐

(b) Declined offer because of salary reasons? .... 173 174 175 ☐☐☐

(c) Declined offer because of job factors (e.g., nature of duties, staffing, etc.)? .... 176 177 178 ☐☐☐

(d) Declined offer because of working conditions (e.g., environment, lack of equipment, etc.)? .... 179 180 18 ☐☐☐

(e) Declined due to delays in the recruitment process? ..... 182 183 184 ☐☐☐

(f) Declined offer because of other reasons? .... 185 186 187 ☐☐☐

(g) Did not meet qualifications standards? .... 188 189 190 ☐☐☐

(h) Were not selected for other reasons? .... 191 192 193 ☐☐☐

17. (a) Has your facility considered requesting special rates for this occupation?

1 = Yes
2 = No

194 ☐

(b) If special rates have not been requested, to what extent was that decision affected by the requirement that the facility must fund the additional costs?

1 = None
2 = Partly
3 = Completely

195 ☐

(c) If special rates are in effect, have they been helpful in resolving the staffing problem?

1 = Yes
2 = Partially
3 = No

196 ☐

18. Any additional comments? (Please type comments on page A-7. Attach additional sheet if necessary.)

19. Name and title of person completing form

____

20. FTS Number ______________________________

VA FORM 10-20826A(NR)
DEC 1986

Attachment B

CIRCULAR 10-86-134

HEALTH OCCUPATIONS SURVEY
(RCS 10-86-22)

	2 3 4
Facility No.	☐☐☐

1. Occupation for which this form is being completed:

	5 6
14 = Nursing Service	1 4

2. (a) Number of staff on duty as of October 1, 1986:

7 8 9	10 11 12	13 14 15	16 17 18
FTP ☐☐☐	RN ☐☐☐	LPN ☐☐☐	NA ☐☐☐

(b1) Number of authorized FTEE:

19 20 21 22 23 24	25 26 27 28 29 30	31 32 33 34 35 3
RN ☐☐☐☐.☐☐	LPN ☐☐☐☐.☐☐	NA ☐☐☐☐.☐☐

	37 38 39 40 41 4
(b2) Number of budgeted FTEE	☐☐☐☐.☐☐
	43 44 45
(c1) Number of full-time staff having less than 1 year of service	☐☐☐
	46 47 48
(c2) Less than 2 years of service	☐☐☐
	49 50 51
(d) Number of full-time staff gains during FY '86	☐☐☐
	52 53 54
(e) Number of full-time staff losses during FY '86	☐☐☐

3. Are sufficient funding and ceiling available to provide authorized staffing level if candidates are available?

	55
1 = Yes 2 = No	☐

4. How many of the losses between October 1, 1985 and September 30, 1986 left for the following reasons?

(a) Higher pay for the same assignment level:

56 57 58	59 60 61	62 63 64
RN ☐☐☐	LPN ☐☐☐	NA ☐☐☐

(b) Higher level position with higher pay:

65 66 67	68 69 70	71 72 73
RN ☐☐☐	LPN ☐☐☐	NA ☐☐☐

(c) Higher level position without higher pay:

74 75 76	77 78 79	80 81 82
RN ☐☐☐	LPN ☐☐☐	NA ☐☐☐

(d) Same pay but better fringe benefits:

83 84 85	86 87 88	89 90 91
RN ☐☐☐	LPN ☐☐☐	NA ☐☐☐

(e) Educational reasons:

92 93 94	95 96 97	98 99 100
RN ☐☐☐	LPN ☐☐☐	NA ☐☐☐

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4. (f) Private practice:

101 102 103 104 105 106 107 108 109
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

(g) Family reasons:

110 111 112 113 114 115 116 117 118
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

(h) Different type of patient care environment:

119 120 121 122 123 124 125 126 127
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

(i) Relocation:

128 129 130 131 132 133 134 135 136
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

(j) Retirement:

137 138 139 140 141 142 143 144 145
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

(k) Involuntary separation:

146 147 148 149 150 151 152 153 154
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

(l) Changes of job assignment:

155 156 157 158 159 160 161 162 163
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

(m) Changes occurring in Federal employment (e.g., retirement coverage, benefits, etc.):

164 165 166 167 168 169 170 171 172
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

(n) Workload:

173 174 175 176 177 178 179 180 181
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

(o) Other:

182 183 184 185 186 187 188 189 190
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

(Please specify) ______________________________

____

5. How many of the gains between October 1, 1985 and September 30, 1986 were most recently employed in the following situations?

(a) Other VA facility:

191 192 193 194 195 196 197 198 199
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

(b) Non-VA Federal medical facility:

200 201 202 203 204 205 206 207 208
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

(c) Private sector medical facility:

209 210 211 212 213 214 215 216 217
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

(d) Other medical related employment (private practice, consultant, etc.):

218 219 220 221 222 223 224 225 226
RN ☐☐☐ LPN ☐☐☐ NA ☐☐☐

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5. (e) Recent Graduate:

RN	227 228 229 ☐☐☐	LPN	230 231 232 ☐☐☐	NA	233 234 235 ☐☐☐

(f) Non-medical employment:

RN	236 237 238 ☐☐☐	LPN	239 240 241 ☐☐☐	NA	242 243 244 ☐☐☐

(g) Military service:

RN	245 246 247 ☐☐☐	LPN	248 249 250 ☐☐☐	NA	251 252 253 ☐☐☐

(h) Unemployment:

RN	254 255 256 ☐☐☐	LPN	257 258 259 ☐☐☐	NA	260 261 262 ☐☐☐

(i) VA Scholarship recipient (service obligation):

RN	263 264 265 ☐☐☐	LPN	266 267 268 ☐☐☐	NA	269 270 271 ☐☐☐

(j) Other:

RN	272 273 274 ☐☐☐	LPN	275 276 277 ☐☐☐	NA	278 279 280 ☐☐☐

(Please specify) ____________________

____

6. (a) Has this service lost any FTEE in the past 3 years to other services because of your difficulty in recruiting applicants?

1 = Yes
2 = No

281 ☐

(b) If yes, how many? .... 282 283 284 285 286 287 ☐☐☐☐.☐☐

7. How comparable to VA pay is the average pay for RNs at the journeyman level at non-Federal medical facilities in your area?

1 = Much more ($4,000 per annum or more) at other facilities
2 = More (up to $4,000 per annum more) at other facilities
3 = Comparable
4 = Less (up to $4,000 less) at other facilities
5 = Much less ($4,000 per annum or more) at other facilities
6 = Don't know

288 ☐

8. Do any of the following pay practices for RNs at other medical facilities in your area put the VA at a disadvantage?

1 = Yes
2 = No

(a) Regular pay increases .... 289 ☐

(b) Overtime .... 290 ☐

(c) Holiday shift .... 291 ☐

(d) Weekend premium pay (e.g., the Baylor Plan) .... 292 ☐

(e) Other (please specify) ____________________ 293 ☐

____

____

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9. Do any of the following "fringe" benefits or packages for RNs at other medical facilities put the VA at disadvantage?

1 = Yes
2 = No

(a) Health insurance .... 294 ☐

(b) Tuition assistance .... 295 ☐

(c) Incentive award program .... 296 ☐

(d) Retirement program .... 297 ☐

(e) Day care for children .... 298 ☐

(f) Vacation or personal leave time .... 299 ☐

(g) Sick leave .... 300 ☐

(h) Other (please specify) ____________________ 301 ☐

____

____

10. Have alternative methods of coverage (e.g., additional shifts, contracting out, etc.) been necessary?

1 = Yes
2 = No

302 ☐

11. (a) Have you employed individuals from other occupations to support the deficiencies in nursing service?

1 = Yes
2 = No

303 ☐

(b) If so, please identify the types of other occupations and the number employed.

Type of other occupation ____________________ 304 305 ☐☐

Number employed .... 306 307 308 ☐☐☐

Type of other occupation ____________________ 309 310 ☐☐

Number employed .... 311 312 313 ☐☐☐

Type of other occupation ____________________ 314 315 ☐☐

Number employed .... 316 317 318 ☐☐☐

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12. (a) Are you affiliated with educational institutions to provide training in this field?

1 = Yes
2 = No

319 ☐

(b) If so, how many students have been trained annually at your facility (average number for FY '84, '85, and '86)?

RN 320 321 322 ☐☐☐ LPN 323 324 325 ☐☐☐ NA 326 327 328 ☐☐☐

(c) How many former students trained at your facility were hired at your facility during FY '86?

RN 329 330 331 ☐☐☐ LPN 332 333 334 ☐☐☐ NA 335 336 337 ☐☐☐

13. How frequently, if at all, were the following RN recruitment techniques utilized during the past fiscal year?

1 = Not Used
2 = Used 1-3 Times
3 = Used 4 or More Times

(a) Newspaper ads .... 338 ☐

(b) Professional journals .... 339 ☐

(c) Referral .... 340 ☐

(d) College visits .... 341 ☐

(e) Pamphlets .... 342 ☐

(f) Job fairs .... 343 ☐

(g) Professional meetings or conferences .... 344 ☐

(h) Professional associations .... 345 ☐

(i) Health Profession Programs .... 346 ☐

14. How effective were these techniques?

1 = No applications from this sources
2 = 1-5 applications received
3 = More than 5 applications received

(a) Newspaper ads .... 347 ☐

(b) Professional journals .... 348 ☐

(c) Referral .... 349 ☐

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Occupation ☐

(d) College visits .... 350 ☐

(e) Pamphlets .... 351 ☐

(f) Job fairs .... 352 ☐

(g) Professional meetings or conferences .... 353 ☐

(h) Professional associations .... 354 ☐

(i) Health Profession programs .... 355 ☐

15. What was the number of RN applications received during the past fiscal year from all sources? 356 357 358 ☐☐☐

16. Of the applications received, how many persons

(a) Were subsequently employed by your facility? .... 359 360 361 ☐☐☐

(b) Declined offer because of salary reasons? .... 362 363 364 ☐☐☐

(c) Declined offer because of job factors (e.g., nature of duties, staffing, etc.)? .... 365 366 367 ☐☐☐

(d) Declined offer because of working conditions (e.g., environment, lack of equipment, etc.)? .... 368 369 370 ☐☐☐

(e) Declined offer because of other reasons? .... 371 372 373 ☐☐☐

(f) Did not meet qualifications standards? .... 374 375 376 ☐☐☐

(g) Were not selected for other reasons? .... 377 378 379 ☐☐☐

17. (a) Has your facility considered requesting special rates for this occupation?

1 = Yes
2 = No

RN 380 ☐ LPN 381 ☐

(b) If special rates have not been requested, to what extent was that decision affected by the requirement that the facility must fund the additional costs?

1 = None
2 = Partly
3 = Completely

RN 382 ☐ LPN 383 ☐

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CIRCULAR 10-86-134
Facility No.
Occupation [illegible]

17. (c) If special rates are in effect, have they been helpful in resolving the staffing problem?

1 = Yes
2 = Partially
3 = No

[illegible]
RN ☐

[illegible]
LPN ☐

18. (a) Do you have a Nurse Recruiter?

1 = Yes
2 = No

[illegible]
☐

19. Any additional comments? (Please type comments on page B-8. Attach additional sheet if necessary.)

20. Name and title of person completing form

____

21. FTE Number ________________________________

ATTACHMENT C

CODING INSTRUCTIONS FOR VA FORMS 10-20826A(NR) AND 10-20826B(NR)
HEALTH OCCUPATIONS SURVEY

Item — **Instructions**

Facility No.

Enter the hospital's three digit number at the top of each of the pages as follows:
On page A-1 and B-1, enter 1 digit in each of the 3 boxes.

Example:

6	4	1

On the remaining pages, write the 3 digits on the line next to "Facility No."

1; Occupation

Attachment A only:
In item 1, enter the code number of the occupation for which the form is being completed as follows:
For codes 1 through 9, enter the number in the right-most box.

Example:

	3

For codes 10 through 13, enter 1 digit in each of the 2 boxes.

Example:

1	2

Then write that number at the top of the remaining pages in the blank line next to "Occupation."
Attachment B only:
The code for Nursing Service has already been entered.

Attachment A 2(a1)

Enter the number of full-time permanent staff in the occupation designated in item 1.
The number must be RIGHT-JUSTIFIED in the boxes provided, as in the following example.

Example: If there were 14 FTP staff, enter 1 in the middle box and 4 in the right-most box. Leave the left-most box empty.

	1	4

Attachment A 2(a2)

Enter the number of FTEE of full-time temporary and part-time employees as follows:
If this is a whole number, right-justify the answer in the three boxes before the decimal point.

Example:

	1	1	.		

If the number is fractional, such as 7.5, right-justify the whole part of the number before the decimal point and enter the fractional part after the decimal.

Example:

		7	.	5	

Attachment B 2(a)	Right-justify (as described for item 2(a1)) the following number of staff: FTP: Enter the total combined number of full-time permanent RN's, LPN's/LVN's, and Nursing Assistants (NA's). RN, LPN, and NA: Enter the number of full-time permanent, full-time temporary, and part-time staff for each of the 3 occupations.
Attachment A 2(b)	Enter authorized FTEE as of October 1, 1986 as described for whole or fractional numbers in item 2(a2).
Attachment B 2(b1)	Enter authorized FTEE as of October 1, 1986 for each of the 3 occupations as described for whole or fractional numbers in item 2(a2).
Attachment B 2(b2)	Enter the budgeted number of FTEE as of October 1, 1986 for the 3 occupations combined. Follow instructions for entering whole or fractional numbers as described in item 2(a2).
2(c1), 2(c2)	Leave these blank if your facility had no full-time staff on October 1, 1986 in this occupation. Consider only time spent in this occupation at your facility in determining an employee's years of service. Employees with less than 1 year's service are also counted in the number of full-time staff with less than 3 years of service. Right-justify the answers as described in item 2(a1). Attachment B only: Provide the combined total for the 3 nursing occupations.
2(d), 2(e)	Right-justify the answers as described in item 2(a1).
3	Write either 1 for "Yes" or 2 for "No" in the box.
Attachment A 4(a)-4(n)	If there were no losses of full-time permanent staff in this profession, leave these items blank. If an individual left for more than 1 reason, he should be included in the count of each of the reasons which apply. Right-justify all answers as described in item 2(a1). Put a 0 in the right-most box if no employees left for a listed reason.
Attachment A 4(n)	Fill in the total number of persons leaving for all reasons other than those mentioned in items 4(a)-4(m). Specify the various reasons on the lines provided.
Attachment B 4(a)-4(o)	Follow instructions for items 4(a)-4(n) of Attachment A, except include losses of BOTH full-time and part-time permanent employees. Provide separate answers for each of the 3 occupations.
Attachment B 4(o)	Fill in the total number of full-time and part-time permanent employees leaving for all reasons other than those mentioned in items 4(a)-4(n). Specify the various reasons on the lines provided.

Attachment A 5(a)-5(i)	If there were no gains of full-time permanent employees, leave these items blank. Count each person gained in NO MORE THAN 2 of the 9 situations. Right-justify all answers as described in item 2(a1). Put a 0 in the right-most box if no employees were previously in a listed situation.
Attachment A 5(i)	In the box provided, fill in the total number of persons who were most recently employed in situations other than those mentioned in items 5(a)-5(h). Specify the various situations on the lines.
Attachment B 5(a)-5(j)	Follow instructions for items 5(a)-5(i) of Attachment A, except include gains of BOTH full-time and part-time permanent employees. Count each person gained in no more than 2 of the 10 situations. Provide separate answers for RN's, LPN's/LVN's, and NA's.
Attachment B 5(j)	Fill in the total number of persons who were most recently employed in situations other than those mentioned in items 5(a)-5(i). Specify the various situations on the lines provided.
6(a)	If the question is not applicable, leave this item blank. Otherwise, write either 1 for "Yes" or 2 for "No" in the box. Attachment B only: Provide the answer for the 3 nursing occupations combined.
6(b)	If item 6(a) is blank or 2 for "No," leave 6(b) blank. If item 6(a) is 1 for "Yes," enter the number of FTEE as described in item 2(a2). Attachment B only: Provide the answer for the 3 nursing occupations combined.
7	In the box, write the number of the appropriate answer from the six choices listed. Leave blank if the question is not applicable. Attachment B only: Provide the answer for RN's only.
Attachment A 8(a)-8(f), 9(a)-9(h)	If there is a difference between the VA and other medical facilities, but the difference does not put the VA at a disadvantage, write 2 for "No" in the box. If there is no difference between the VA and other facilities, also write in 2. If the entire question is not applicable, leave all items blank.
Attachment B 8(a)-8(e), 9(a)-9(h)	Follow instructions for items 8(a)-8(f), 9(a)-9(h) of Attachment A. Provide the answers for RN's only.
10, 11(a)	Write either 1 for "Yes" or 2 for "No" in the box. Attachment B only: Provide the answer for the 3 nursing occupations combined.

11(b) If item 11(a) is 2 for "No," leave 11(b) blank.
Otherwise, on the long lines provided to the right of "Type of other occupation," write the titles of the occupation which were substituted for the occupation for which the form is be completed. Do not enter anything in the boxes next to the line.
In the box by "Number employed," right-justify (as in item 2(a1)) the number of persons with that title which were used.
If more than 3 "Types of other occupation" were employed, write them and the "Number employed" in item 18.

12(a) Write either 1 for "Yes" or 2 for "No" in the box.

12(b) Leave this item blank if 12(a) is "No."
Otherwise, obtain the rounded AVERAGE as follows:
If your facility has been affiliated with educational institutions to provide training, but no students were trained in this occupation, fill in 0 in the right-most box.
If your facility has been affiliated for all 3 years, total the number of students trained in each of the 3 years, divide by 3, and round to the nearest whole number.
ROUND as follows:
After dividing, if the 1st digit after the decimal point is less than 5, round the entire number to the whole number before the decimal.
Example: 7.4 rounds to 7
If the 1st digit after the decimal is 5 or greater, round the entire number to the next highest whole number.
Example: 8.6 rounds to 9
If your facility has only been affiliated since FY '85, tota the number of students trained in FY '85 and '86, divide by 2, and round.
If your facility has only been affiliated since FY '86, enter the number of students trained in FY '86.
Right-justify the rounded answer as described in item 2(a1).
Example: 4 students were trained in FY '84, 0 in FY '85, and 9 in FY '86. The total is 13, the average for the 3 years is 4.3, which rounds to 4.

		4

Attachment B only:
Provide separate answers for RN's, LPN's/LVN's, and NA's.

12(c) Leave this item blank if 12(a) is "No."
Otherwise, right-justify the answer as described in item 2(a1).
Attachment B only:
Provide separate answers for RN's, LPN's/LVN's, and NA's.

Attachment A 13(a)-13(g) If no recruiting at all was done in the past fiscal year, leave all boxes blank.

Attachment B 13(a)-13(i) Follow instructions for items 13(a)-13(g) of Attachment A.
Provide answers for RN's only.

Attachment A 14(a)-14(g)	If no recruiting at all was done in the past fiscal year or if none of the 7 techniques listed in items 13(a)-13(g) was used, leave all these items blank. Fill in the appropriate code (1, 2, or 3) for effectiveness only on techniques which were used at least once. If an item in 13(a) to 13(g) was left blank or coded 1 for "Not Used", leave the corresponding item in question 14 blank.
Attachment B 14(a)-14(i)	If no recruiting at all was done in the past fiscal year or if none of the 9 techniques listed in items 13(a)-13(i) was used, leave all these items blank. Fill in the appropriate code (1, 2, or 3) for effectiveness only on techniques which were used at least once. If an item in 13(a) to 13(i) was left blank or coded 1 for "Not Used", leave the corresponding item in question 14 blank. Provide answers for RN's only.
15	Right-justify the numbers as described in item 2(a1). Attachment B only: Provide the answer for RN's only.
Attachment A 16(a)-16(h)	If no applications at all were received, leave items 16(a) through 16(h) blank. If an individual declined an offer for more than one of the reasons listed in 16(b)-16(f), count that person in the main reason only. Right-justify the answers as described in item 2(a1).
Attachment B 16(a)-16(g)	If no applications at all were received, leave items 16(a) through 16(g) blank. If an individual declined an offer for more than one of the reasons listed in 16(b)-16(e), count that person in the main reason only. Right-justify the answers as described in item 2(a1). Provide answers for RN's only.
17(a)	Write 1 for "Yes" or 2 for "No" in the box provided. Attachment B only: Provide separate answers for RN's and LPN's.
17(b)	If item 17(a) is 2 for "No," leave item 17(b) blank. Otherwise, write the appropriate answer (1,2, or 3) in the box provided. Attachment B only: Provide separate answers for RN's and LPN's.
17(c)	If special rates are not in effect, leave this item blank. Attachment B only: Provide separate answers for RN's and LPN's.
Attachment A 18	Attachment B only: Provide separate answers for RN's and LPN's. Type comments on page A-7. If more space is needed for comments, please attach additional sheets to the form. Write the facility number and occupation number at the top of each page.

Attachment B 18	Enter either 1 for "Yes" or 2 for "No" in the box.
Attachment A 19, 20	Type or print the name and title of the person at the facility who completed the form, and the FTS number at which he/she may be contacted.
Attachment B 19	Follow instructions for item 18 of Attachment A, except type comments on page B-8.
Attachment B 20, 21	Follow instructions for items 19 and 20 of Attachment A.

APPENDIX B

METHODOLOGY

General

The survey instrument was developed by staff in the Office of Personnel and Labor Relations, the Department of Medicine and Surgery, and the Office of Information Management and Statistics. It asked medical facilities to respond to various questions which provided information on such issues as reasons for losses, private-sector pay practices and benefits packages, effectiveness of various recruitment techniques, and sources of applications.

The medical facilities sent their completed survey forms to the Office of Personnel and Labor Relations where they were reviewed for completeness. After keypunching, the responses were processed by a computer program designed by the Office of Information Management and Statistics. The computer-generated statistics were reviewed and analyzed by the Office of Information Management and Statistics and the Office of Personnel and Labor Relations. The responses from each facility and the statistics by facility, medical district, and region were examined with primary emphasis on identification of occupational trends.

Because this survey was a first, it could not be compared with prior results. Minor contradictions for some employment statistics, which we presume reflect survey errors, were found with Personnel and Accounting Integrated Data (PAID) system data. Naturally, there also may be errors in data, such as salary levels at non-VA facilities, which we would not be able to verify.

Some errors also may result from different and inconsistent interpretations of the questions by field officials. Another potential source of error could be the use of estimations rather than recently collected statistics. Such estimations might have been affected by very real concerns about recruiting and retaining essential employees.

Staffing Index

Recruitment and retention in each occupation is reflected in the Staffing Index which is based on two ratios: (1) Vacancy Rate; and (2) Net Gain or Loss Rate.

The Vacancy Rate shows the ratio between vacancies and authorized full-time employment equivalents (FTEEs) on September 30, 1986. The Vacancy Rate is the following:

$$\text{VACANCY RATE} = \frac{\text{Authorized FTEE} - (\text{Strength})}{\text{Authorized FTEE}} \times 100$$

(The Authorized FTEE was as reported by the medical facilities, and the Strength was the actual FTEE.) At facilities where strength exceeded authorized FTEE, the Vacancy Rate was negative. Where strength and ceiling matched, facilities had a Vacancy Rate of zero. Facilities which had vacancies had positive Vacancy Rates. The size of the Vacancy Rate depended on the proportion of the authorized FTEE remaining vacant.

The Vacancy Rates in occupations, such as occupational therapy, with relatively small numbers of positions at some facilities may be disproportionately raised by individual vacancies. For example, at a facility with two occupational therapist positions, the Vacancy Rate would be 50 if one of the positions was vacant ((2 - 1) / 2 X 100). On the other hand, at a facility with 600 registered nurses, 10 vacancies would represent a Vacancy Rate of 1.7 ((600 - 590) / 600 X 100).

The Net Gain or Loss Rate is the following:

$$\text{NET GAIN OR LOSS RATE} = \frac{\text{Gains - Losses}}{\text{Full-time permanent (FTP) staff}} \times 100$$

(The gains and losses were for Fiscal Year 1986, and the FTP staff was as of 9/30/86.) If gains exceeded losses, the net rate would be positive, i.e., a Net Gain Rate. If losses exceed gains, the net rate would be negative, i.e., a Net Loss Rate.

Both the Vacancy Rate and the Net Gain or Loss Rate were multiplied by 100 to convert the percentages into whole numbers.

The survey document for Nursing Service did not ask for separate gain and loss data for each of the nursing occupations. This information was obtained from the PAID system.

The Vacancy Rates and the Net Gain or Loss Rates were combined in the Staffing Index to rank facilities' recruitment and retention difficulties. Facilities with an index of zero or less (negative numbers) indicated favorable staffing conditions. Recruitment and retention difficulties were expressed in positive numbers, with higher numbers reflecting greater difficulties.

Staffing Index values have been used in charts which designate the facilities' staffing situations as favorable or moderately, seriously, or severely difficult. For example, favorable conditions would typically occur at facilities which are fully staffed and gains have equaled or exceed losses. However, a facility would also be categorized as having favorable conditions despite vacancies if the Net Gain Rate exceeded the Vacancy Rate.

Difficult conditions are typically represented by current vacancies and losses exceeding gains. Although a Net Gain Rate represents a favorable condition, a facility may still be categorized as having overall recruitment and retention difficulty based on a relatively high Vacancy Rate.

Generally, staffing conditions worsen with increases in both Vacancy Rates and Net Loss Rates. Categories of difficulties for the facilities were determined by examining the range of Staffing Index values for each occupation and identifying three clusters of values which were equated to moderately, seriously, and severely difficult recruitment and retention conditions. Since the clusters of values varied by occupation, direct comparisons of Staffing Index clusters between occupations are of limited validity.

The Staffing Index is a constructed measure, which while useful as a guide is not an absolutely reliable measure of recruitment and retention. It does not take into account many factors in the staffing process, such as the length and frequency of vacancies and changes in authorized FTEE.

Turnover Rate

Turnover Rate was also used to reflect retention. The formula for Turnover Rate is the following:

$$\text{TURNOVER RATE} = \frac{\text{Losses}}{\text{FTP}}$$

(The losses were for Fiscal Year 1986, and the FTP was as of 9/30/86.)

APPENDIX C

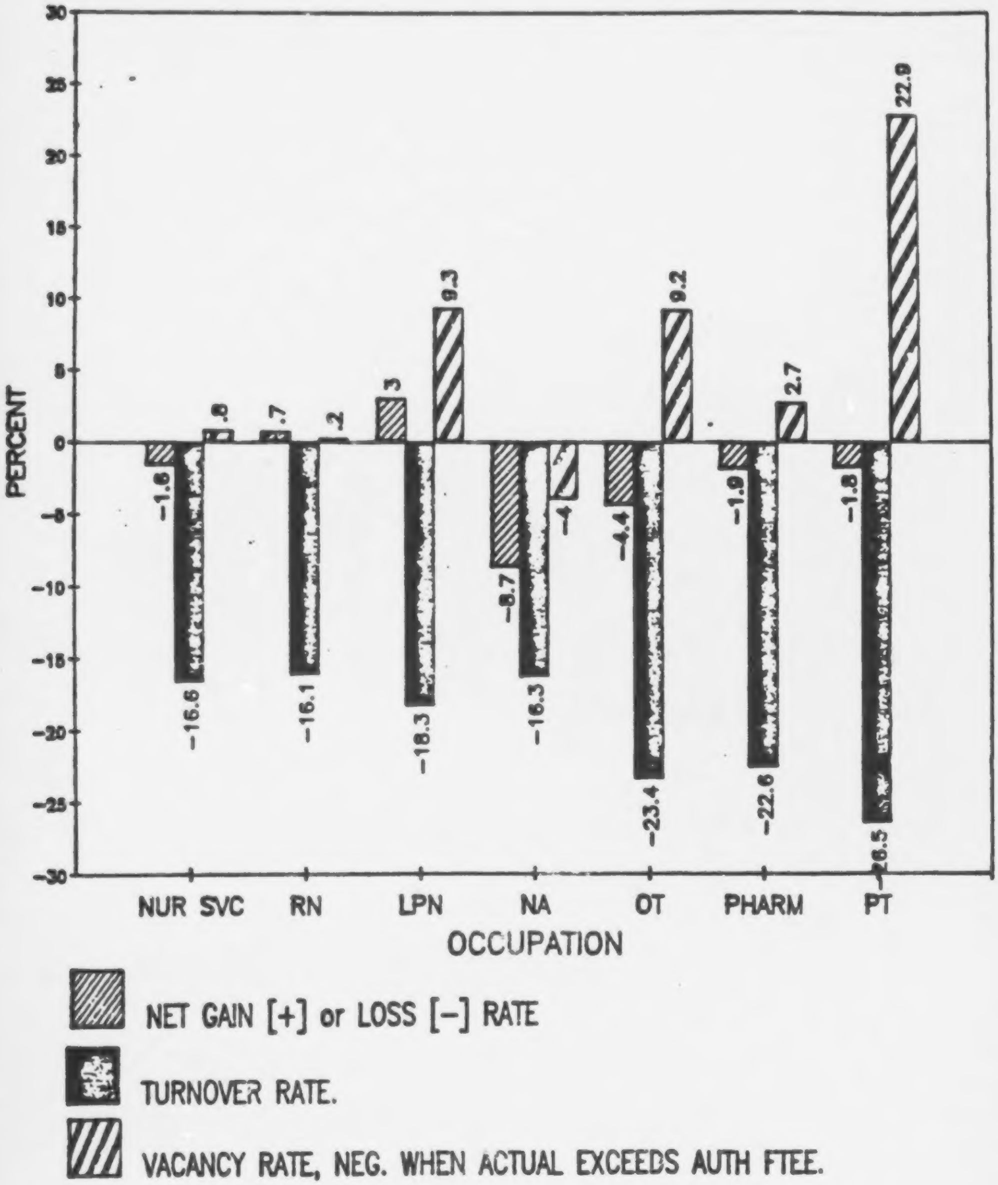
TABLE OF
STAFFING DATA BY OCCUPATION

OCCUPATION	TURNOVER RATE	NET GAIN (+) OR LOSS (-) RATE	VACANCY RATE*
Nursing	16.6%	-1.6%	0.8%
Registered Nurses	16.1%	+0.7%	0.2%
Licensed Practical Nurses	18.3%	+3.0%	9.3%
Nursing Assistants	16.3%	-8.7%	-4.0%
Occupational Therapists	23.4%	-4.4%	9.2%
Pharmacists	22.6%	-1.9%	2.7%
Physical Therapists	26.5%	-1.8%	22.9%
Respiratory Therapists	21.3%	+2.9%	15.9%
Diagnostic Radiologic Technicians/Technologists	16.9%	-1.5%	5.0%
Therapeutic Radiologic Technicians/Technologists	26.2%	0.0%	15.1%
Dental Assistants	19.3%	-0.4%	2.5%
Deantal Hygienists	21.5%	+0.6%	7.2%
Echocardiograph Technicians	14.4%	+2.0%	3.6%
Nuclear Medicine Technicians	11.3%	-0.8%	2.7%
Nuclear Medicine Technologists	11.7%	+3.3%	2.0%
Opthalmologist Technicians	15.0%	0.0%	11.0%
Pulmonary Function Technicians	8.6%	-2.0%	1.9%

*Negative when actual FTEE exceeds authorized FTEE

APPENDIX D

FY 1986 STAFFING DATA BY OCCUPATION

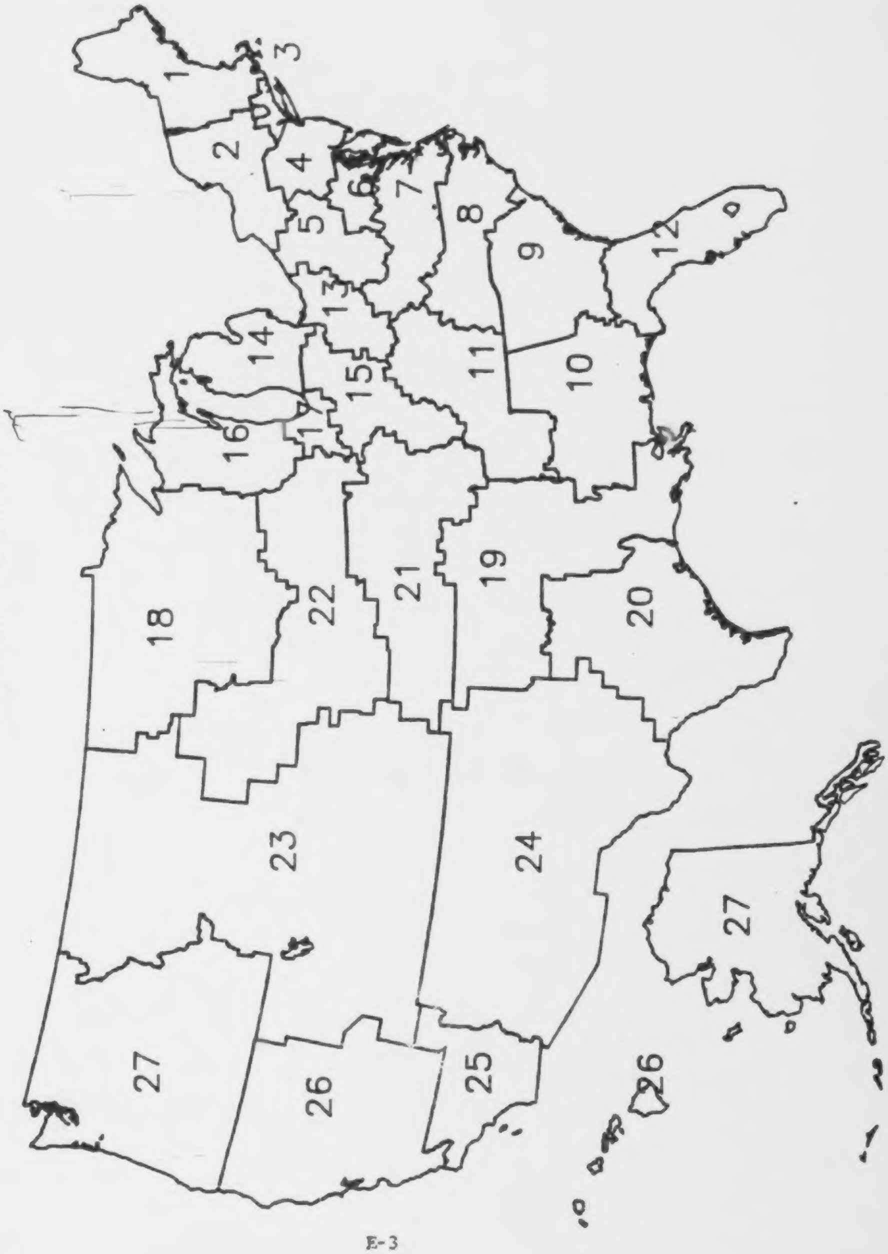


APPENDIX E

REGIONAL/MEDICAL DISTRICT LISTING

REGION I	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION VII
DIST 1 Bedford, MA Boston, MA Boston, MA, OPC Brockton, MA Manchester, NH Northhampton, MA Providence, RI Togus, ME Wh River, JCT, VT	**DIST 4** Coatesville, PA E. Orange, NJ Lebanon, PA Lyons, NJ Philadelphia, PA Wilkes-Barre, PA Wilmington, DE	**DIST 9** Decatur, GA Augusta, GA Charleston, SC Columbia, SC Dublin, GA	**DIST 13** Chillicothe, OH Cincinnati, OH Cleveland, OH Columbus, OH,OPC Dayton, OH	**DIST 18** Minneapolis, MN St. Cloud, MN Sioux Falls, SD Fargo, ND	**DIST 25** Las Vegas, NV, OPC Loma Linda, CA Long Beach, CA Los Angeles, CA,OPC San Diego, CA Sepulveda, CA West Los Angeles,CA	**DIST 19** Alexandria, LA Little Rock, AR Fayetteville, AR New Orleans, LA Shreveport, LA Muskogee, OK Oklahoma City, OK
DIST 2 Albany, NY Batavia, NY Bath, NY Buffalo, NY Canandaigua, NY Syracuse, NY	**DIST 5** Altoona, PA Butler, PA Clarksburg, WV Erie, PA Pittsburgh, (HD), PA Pittsburgh, (UD), PA	**DIST 10** Biloxi, MS Birmingham, AL Jackson, MS Montgomery, AL Tuscaloosa, AL Tuskegee, AL	**DIST 14** Allen Park, MI Ann Arbor, MI Battle Creek, MI Saginaw, MI	**DIST 21** Columbia, MO Poplar Bluff, MO St. Louis, MO Kansas City, MO Leavenworth, KS Topeka, KS Wichita, KS Marion, IL	**DIST 26** Fresno, CA Honolulu, HI,OPC Livermore, CA Martinez, CA Palo Alto, CA Reno, NV San Fran., CA	**DIST 20** Bonham, TX Dallas, TX Houston, TX Kerrville, TX Marlin, TX San Antonio, TX Temple, TX Waco, TX
DIST 3 Bronx, NY Brooklyn, NY Castle Point, NY Montrose, NY Newington, CT New York, NY Northport, NY San Juan, PR W. Haven, CT	**DIST 6** Baltimore, MD Ft. Howard, MD Martinsburg, WV Perry Point, MD Washington, DC	**DIST 11** Lexington, KY Louisville, KY Memphis, TN Murfreesboro, TN Nashville, TN	**DIST 15** Danville, IL Ft. Wayne, IN Indianapolis, IN Marion, IN	**DIST 22** Des Moines, IA Ft. Meade, SD Grand Island, NE Hot Springs, SD Iowa City, IA Knoxville, IA Lincoln, NE Omaha, NE	**DIST 27** Anchorage AK, OPC American Lake Tacoma, WA Boise, ID Portland, OR Roseburg, OR Seattle, WA Spokane, WA Walla Walla, WA White City, OR	**DIST 24** Albuquerque, NM Amarillo, TX Big Spring, TX El Paso, TX, OPC Phoenix, AZ Prescott, AZ Tucson, AZ
	DIST 7 Beckley, WV Hampton, VA Huntington, WV Richmond, VA Salem, VA	**DIST 12** Bay Pines, FL Gainesville, FL Lake City, FL Miami, FL Tampa, FL	**DIST 16** Iron Mt., WI Madison, WI Tomah, WI Milwaukee, WI	**DIST 23** Cheyenne, WY Denver, CO Fort Harrison, MT Fort Lyon, CO Grand Junction, CO Miles City, MT Salt Lake City, UT Sheridan, WY		
	DIST 8 Asheville, NC Durham, NC Fayetteville, NC Mt. Home, TN Salisbury, NC		**DIST 17** Chicago(LS), IL Chicago,(WS), IL N. Chicago, IL Hines, IL			

DM&S MEDICAL DISTRICTS


1
2
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23
24
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26
27
27
26

APPENDIX F

FACILITIES CATEGORIZED BY VETERAN POPULATION PER PRIMARY SERVICE AREA

Category I - Vet Pop per PSA - less than 50K

ST	FACILITY
442	CHEYENNE
514	BATH
517	BECKLEY
522	BONHAM
574	GRAND ISLAND
575	GRAND JUNCTION
579	HOT SPRINGS
591	KERRVILLE
597	LINCOLN
617	MILES CITY
649	PRESCOTT
686	LEAVENWORTH

Category II - Vet Pop per PSA - 50K to 100K

ST	FACILITY
363	ANCHORAGE
405	WHITE RIVER JUNCTION
436	FORT HARRISON
503	ALTOONA
504	AMARILLO
509	AUGUSTA
531	BOISE
533	CASTLE POINT
540	CLARKSBURG
550	DANVILLE
562	ERIE
585	IRON MOUNTAIN
596	LEXINGTON
637	ASHEVILLE
647	POPLAR BLUFF

Category II - Vet Pop per PSA - 50K to 100K (continued)

ST	FACILITY
653	ROSEBURG
654	RENO
658	SALEM
668	SPOKANE
677	TOPEKA
680	TUSKEGEE
687	WALLA WALLA
692	WHITE CITY

Category III - Vet Pop per PSA - 100K to 250K

ST	FACILITY
359	HONOLULU
402	TOGUS
437	FARGO
438	SIOUX FALLS
452	WICHITA
455	SAN JUAN
460	WILMINGTON
500	ALBANY
501	ALBUQUERQUE
502	ALEXANDRIA
513	BATAVIA
519	BIG SPRING
520	BILOXI
521	BIRMINGHAM
528	BUFFALO
529	BUTLER
534	CHARLESTON
539	CINCINNATI
543	COLUMBIA, MO

Category III - Vet Pop per PSA - 100K to 250K (continued)

ST	FACILITY
544	COLUMBIA, SC
555	DES MOINES
557	DUBLIN
558	DURHAM
564	FAYETTEVILLE, AR
565	FAYETTEVILLE, NC
569	FORT WAYNE
570	FRESNO
581	HUNTINGTON
584	IOWA CITY
586	JACKSON
589	KANSAS CITY
590	HAMPTON
594	LAKE CITY
595	LEBANON
598	LITTLE ROCK
603	LOUISVILLE
607	MADISON
608	MANCHESTER
609	MARION, IL
611	MARLIN
613	MARTINSBURG
614	MEMPHIS
619	MONTGOMERY
621	MOUNTAIN HOME
623	MUSKOGEE
627	NEWINGTON
629	NEW ORLEANS
636	OMAHA
644	PHOENIX
650	PROVIDENCE
652	RICHMOND
655	SAGINAW
659	SALISBURY
660	SLT LAKE CTY
667	SHREVEPORT
670	SYRACUSE
674	TEMPLE
678	TUCSON

Category IV - Vet Pop per PSA - above 250K

ST	FACILITY
506	ANN ARBOR
508	ATLANTA
512	BALTIMORE
516	BAY PINES
523	BOSTON
525	BROCKTON
526	BRONX
527	BROOKLYN
535	CHICAGO (LS)
537	CHICAGO (WS)
541	CLEVELAND
546	MIAMI
549	DALLAS
552	DAYTON
553	ALLEN PARK
554	DENVER
556	NORTH CHICAGO
561	EAST ORANGE
566	FORT HOWARD
573	GAINESVILLE
578	HINES
580	HOUSTON
583	INDIANAPOLIS
599	LIVERMORE
600	LONG BEACH
605	LOMA LINDA
612	MARTINEZ
618	MINNEAPOLIS
626	NASHVILLE
630	NEW YORK
632	NORTHPORT
635	OKLAHOMA CITY
640	PALO ALTO
642	PHILADELPHIA
646	PITTSBURGH (UD)
648	PORTLAND
657	ST. LOUIS
662	SAN FRANCISCO

Category IV - Vet Pop pe - above 250K (continued)

ST	FACILITY
663	SEATTLE
664	SAN DIEGO
665	SEPULVEDA
671	SAN ANTONIO
673	TAMPA
688	WASHINGTON
689	WEST HAVEN
691	LOS ANGELES
693	WILKES BARRE
695	WOOD
750	BOSTON-IOC
752	LOS ANGELES-IOC
756	EL PASO-IOC
757	COLUMBUS-IOC
758	LAS VEGAS-IOC

Category V - Psychiatric

ST	FACILITY
505	AMERICAN LAKE
515	BATTLE CREEK
518	BEDFORD
532	CANANDAIGUA
538	CHILLACOTHE
542	COATESVILLE
567	FORT LYON
568	FORT MEADE
592	KNOXVILLE, IA
604	LYONS
610	MARION, IN
620	MONTROSE
622	MURFREESBORO
631	NORTH HAMPTON
641	PERRY POINT
645	PITTSBURG (HD)
656	ST CLOUD
666	SHERIDAN
676	TOMAH
679	TUSCALOOSA
685	WACO

CATEGORY	VET POP PER PSA	CATEGORY	VET POP PER PSA
I	50K	IV	250K
II	50K - 100K	V	Psychiatric Fac.
III	100K - 250K		

APPENDIX G

Page No. G-2

VA SPECIAL RATE AUTHORIZATIONS (Sec. 4107)
For Selected Occupations
As of October 1, 1986

State, Facility		Region
**	610 REGISTERED NURSE	
AL	BIRMINGHAM	3
AZ	PHOENIX	7
AZ	TUCSON	7
CA	FRESNO	6
CA	LIVERMORE	6
CA	LOMA LINDA	6
CA	LONG BEACH	6
CA	LOS ANGELES OPC	6
CA	MARTINEZ	6
CA	PALO ALTO	6
CA	SAN DIEGO	6
CA	SAN FRANCISCO	6
CA	SEPULVEDA	6
CA	WEST LOS ANGELES	6
CO	DENVER	5
CO	FT. LYON	5
CT	NEWINGTON	1
CT	WEST HAVEN	1
DC	WASHINGTON	2
DE	WILMINGTON	2
FL	GAINESVILLE	3
FL	MIAMI	3
GA	ATLANTA (DECATUR)	2
GA	AUGUSTA	3
GA	DUBLIN	3
IL	CHICAGO (LAKESIDE)	4
IL	CHICAGO (WEST SIDE)	4
IL	DANVILLE	4
IL	HINES	4
IL	NORTH CHICAGO	4
IN	INDIANAPOLIS	4
KS	LEAVENWORTH	5
KY	LEXINGTON	3
KY	LOUISVILLE	3
LA	ALEXANDRIA	7
LA	NEW ORLEANS	7
LA	SHREVEPORT	7
MA	BEDFORD	1
MA	BOSTON	1
MA	BROCKTON & W ROX	1
MD	BALTIMORE	2
MD	FT. HOWARD	2
MI	ALLEN PARK	4
MI	ANN ARBOR	4
MI	BATTLE CREEK	4
MI	SAGINAW	4
MN	MINNEAPOLIS	5
MN	ST. CLOUD	5

VA SPECIAL RATE AUTHORIZATIONS (Sec. 4107)
For Selected Occupations
As of October 1, 1986

State, Facility		Region
MO	COLUMBIA	5
MO	KANSAS CITY	5
MO	ST. LOUIS	5
NC	DURHAM	3
NC	FAYETTEVILLE	2
NE	OMAHA	5
NJ	EAST ORANGE	1
NJ	LYONS	2
NV	RENO	6
NY	BRONX	1
NY	BROOKLYN	1
NY	MONTROSE	1
NY	NEW YORK CITY	1
NY	NORTHPORT	1
OH	CHILLICOTHE	4
OH	CINCINNATI	4
OH	CLEVELAND	4
OH	DAYTON	4
OK	OKLAHOMA CITY	7
OR	PORTLAND	6
PA	COATESVILLE	2
PA	LEBANON	2
PA	PHILADELPHIA	2
PA	PITTSBURGH HIGHLAND DRIVE	2
PA	PITTSBURGH UNIVERSITY DR	2
SC	CHARLESTON	3
TN	MEMPHIS	3
TN	NASHVILLE	3
TX	BIG SPRING	7
TX	DALLAS	7
TX	HOUSTON	7
TX	MARLIN	7
TX	TEMPLE	7
TX	WACO	7
UT	SALT LAKE CITY	5
WA	SEATTLE	6
WI	TOMAH	4
WI	WOOD	4
WV	CLARKSBURG	2
WV	HUNTINGTON	2
WY	SHERIDAN	5
** 610 REGISTERED NURSE--OPR RM ON CALL 35%		
CA	WEST LOS ANGELES	6
** 620 LICENSED PRACTICAL NURSE		
CT	NEWINGTON	1
CT	WEST HAVEN	1
MA	BEDFORD	1

VA SPECIAL RATE AUTHORIZATIONS (Sec. 4107)
For Selected Occupations
As of October 1, 1986

State,	Facility	Region
MA	BOSTON	1
MA	BOSTON OPC	1
MA	BROCKTON & W ROX(BR ONLY)	1
MA	BROCKTON & W ROX(WR ONLY)	1
MI	ALLEN PARK	4
MI	ANN ARBOR	4
MI	SAGINAW	4
MN	MINNEAPOLIS	5
MO	ST. LOUIS	5
NY	MONTROSE	1
NY	NORTHPORT	1
OK	OKLAHOMA CITY	7
OR	PORTLAND (PTLD & VNCVR)	6
PA	COATESVILLE	2
PA	PHILADELPHIA	2
WI	WOOD	4
**	620 LICENSED VOCATIONAL NURSE	
CA	FRESNO	6
CA	LIVERMORE	6
CA	MARTINEZ	6
CA	PALO ALTO	6
CA	SAN DIEGO	6
CA	SAN FRANCISCO	6
CA	SEPULVEDA	6
CA	WEST LOS ANGELES	6
TX	KERRVILLE	[illegible]
**	631 OCCUPATIONAL THERAPIST	
NE	OMAHA	5
NY	BRONX	1
NY	BROOKLYN	1
NY	NEW YORK CITY	1
NY	NORTHPORT	1
PA	PHILADELPHIA	2
**	633 PHYSICAL THERAPIST	
AR	LITTLE ROCK	7
AZ	PHOENIX	7
CA	FRESNO	6
CA	LIVERMORE	6
CA	LOMA LINDA	6
CA	LONG BEACH	6
CA	LOS ANGELES OPC	6
CA	MARTINEZ	6
CA	PALO ALTO	6
CA	SAN FRANCISCO	6
CA	SEPULVEDA	6
CA	WEST LOS ANGELES	6

VA SPECIAL RATE AUTHORIZATIONS (Sec. 4107)
For Selected Occupations
As of October 1, 1986

State, Facility		Region
DE	WILMINGTON	2
GA	AUGUSTA	3
IN	MARION	4
KY	LOUISVILLE	3
MI	ALLEN PARK	4
MI	ANN ARBOR	4
MI	IRON MOUNTAIN	4
MN	MINNEAPOLIS	5
MN	ST. CLOUD	5
MO	POPLAR BLUFF	5
NE	OMAHA	5
NY	BRONX	1
NY	BROOKLYN	1
NY	NEW YORK CITY	1
NY	NORTHPORT	1
OH	CHILLICOTHE	4
OH	CINCINNATI	4
OH	CLEVELAND	4
OK	OKLAHOMA CITY	7
OR	PORTLAND	6
PA	ALTOONA	2
PA	LEBANON	2
PA	PITTSBURGH HIGHLAND DRIVE	2
PA	PITTSBURGH UNIVERSITY DR	2
PA	WILKES-BARRE	2
SC	CHARLESTON	3
SC	COLUMBIA	3
SD	FT. MEADE	5
SD	HOT SPRINGS	5
SD	SIOUX FALLS	5
TN	MEMPHIS	3
TN	NASHVILLE	3
VA	SALEM	2
WA	SPOKANE	6
WV	BECKLEY	2
WV	HUNTINGTON	2
WY	SHERIDAN	5
** 660 PHARMACIST		
CA	FRESNO	6
CA	LOMA LINDA	6
CA	LONG BEACH	6
CA	LOS ANGELES OPC	6
CA	MARTINEZ	6
CA	PALO ALTO	6
CA	SAN DIEGO	6
CA	SAN FRANCISCO	6
CA	SEPULVEDA	6
CA	WEST LOS ANGELES	6

VA SPECIAL RATE AUTHORIZATIONS (Sec. 4107)
For Selected Occupations
As of October 1, 1986

State, Facility		Region
CO	DENVER	5
DC	WASHINGTON	2
FL	MIAMI	3
FL	TAMPA	3
IL	DANVILLE	4
IN	INDIANAPOLIS	4
KY	LOUISVILLE	3
MN	MINNEAPOLIS	5
MO	ST. LOUIS	5
NC	FAYETTEVILLE	2
NY	BATH	1
NY	NORTHPORT	1
OH	CLEVELAND	4
OK	OKLAHOMA CITY	7
SC	COLUMBIA	3
TN	MURFREESBORO	3
TN	NASHVILLE	3
TX	AMARILLO	7
TX	BIG SPRING	7
TX	DALLAS	7
TX	TEMPLE	7
TX	WACO	7
VA	RICHMOND	2
WA	SEATTLE	6
WA	SPOKANE	6
WI	MILWAUKEE	4
WV	HUNTINGTON	2

VA SPECIAL RATE AUTHORIZATIONS (Sec. 4107)
For Selected Occupations
As of October 1, 1986

CERTIFIED/REGISTERED RESPIRATORY THERAPIST

State, Facility		Region
CA	PALO ALTO	6
CO	DENVER	5
CT	WEST HAVEN	1
IA	IOWA CITY	5
NY	BRONX	1
NY	BROOKLYN	1
NY	NEW YORK CITY	1
NY	NORTHPORT	1
SC	COLUMBIA	3
WA	SEATTLE	6

DIAGNOSTIC RADIOLOGIC TECHNICIAN/TECHNOLOGIST

State, Facility		Region
CA	LIVERMORE	6
CA	LONG BEACH	6
CA	MARTINEZ	6
CA	PALO ALTO	6
CA	SAN FRANCISCO	6
CA	SEPULVEDA	6
CA	WEST LOS ANGELES	6
CO	DENVER	5
GA	ATLANTA (DECATUR)	3
NY	NORTHPORT	1
NY	BRONX	1
NY	BROOKLYN	1
WA	SEATTLE	6

THERAPEUTIC RADIOLOGIC TECHNICIAN/TECHNOLOGIST

State, Facility		Region
CA	LIVERMORE	6
CA	LONG BEACH	6
CA	LOS ANGELES OPC	6
CA	MARTINEZ	6
CA	SAN FRANCISCO	6
CA	WEST LOS ANGELES	6
DC	WASHINGTON	2
IL	CHICAGO (LAKESIDE)	4
IL	CHICAGO (WEST SIDE)	4
IL	HINES	4

VA SPECIAL RATE AUTHORIZATIONS (Sec. 4107)
For Selected Occupations
As of October 1, 1986

State, Facility		Region
THERAPEUTIC RADIOLOGIC TECHNICIAN/TECHNOLOGIST (CONTINUED)		
MA	BOSTON	1
MO	ST. LOUIS	5
NY	ALBANY	1
NY	BRONX	1
NY	BROOKLYN	1
NY	NEW YORK CITY	1
WI	WOOD	4
DENTAL ASSISTANT		
MA	BEDFORD	1
MA	BOSTON	1
MA	BOSTON OPC	1
MA	BROCKTON & W ROX	1
DENTAL HYGIENIST		
CA	FRESNO	6
CA	LIVERMORE	6
CA	LOMA LINDA	6
CA	LONG BEACH	6
CA	LOS ANGELES OPC	6
CA	MARTINEZ	6
CA	PALO ALTO	6
CA	SAN DIEGO	6
CA	SAN FRANCISCO	6
CA	SEPULVEDA	6
CA	WEST LOS ANGELES	6
MA	BEDFORD	1
MA	BOSTON	1
MA	BOSTON OPC	1
MA	BROCKTON & W ROX	1
WA	WALLA WALLA	6
ECHOCARDIOGRAPH TECHNICIAN		
NY	BRONX	1
NY	BROOKLYN	1
NY	NEW YORK CITY	1

VA SPECIAL RATE AUTHORIZATIONS (Sec. 4107)
For Selected Occupations
As of October 1, 1986

State, Facility		Region
NUCLEAR MEDICINE TECHNICIAN		
CA	PALO ALTO	6
CT	WEST HAVEN	1
DC	WASHINGTON	2
NY	BRONX	1
NY	BROOKLYN	1
NY	NEW YORK CITY	1
NUCLEAR MEDICINE TECHNOLOGIST		
NY	BRONX	1
NY	BROOKLYN	1
NY	NEW YORK CITY	1
NY	NORTHPORT	1

Appendix H

Staffing Index Categories by Facility
For each Occupation

NOTE: Facilities are listed by occupations in the order of their Staffing Index Values from lowest (negative numbers) to highest (positive numbers). Lower numbers reflect the more favorable staffing conditions; higher numbers reflect more difficult staffing conditions. The range of Staffing Index Values are shown for each category.

REGISTERED NURSE

FAVORABLE
(-23.7 to 0)

521 Birmingham
623 Muskogee
525 Brockton
635 Oklahoma City
463 Anchorage
522 Bonham
676 Tomah
542 Coatesville
459 Honolulu
537 Chicago (WS)
550 Danville
520 Biloxi
513 Batavia
679 Tuscaloosa
518 Bedford
567 Fort Lyon
605 Loma Linda
647 Poplar Bluff
692 White City
659 Salisbury
570 Fresno
658 Salem
580 Houston
752 Los Angeles - IOC
591 Kerrville
540 Clarksburg
695 Wood
579 Hot Springs
594 Lake City
523 Boston
514 Bath
436 Fort Harrison
527 Brooklyn
535 Chicago (LS)
671 San Antonio
562 Erie
549 Dallas
668 Spokane
455 San Juan
648 Portland
589 Kansas City
442 Cheyenne
574 Grand Island
578 Hines
528 Buffalo
585 Iron Mountain
636 Omaha
632 Northport
575 Grand Junction
504 Amarillo
553 Allen Park
538 Chillicothe
543 Columbia, MO
500 Albany City
686 Leavenworth
664 San Diego
650 Providence
750 Boston - IOC
673 Tampa
612 Martinez
531 Boise
583 Indianapolis
557 Dublin
546 Miami
618 Minneapolis

FAVORABLE
(cont'd.)

607 Madison
529 Butler
573 Gainesville
556 North Chicago
637 Asheville
609 Marion, IL
666 Sheridan
555 Des Moines
598 Little Rock
532 Canandaigua
756 El Paso - IOC

MODERATELY
DIFFICULT
(0.1 to 4.9)

626 Nashville
452 Wichita
506 Ann Arbor
597 Lincoln
677 Topeka
534 Charleston
603 Louisville
654 Reno
596 Lexington
610 Marion, IN
621 Mountain Home
646 Pittsburgh (UD)
640 Palo Alto
516 Bay Pines
595 Lebanon
517 Beckley
688 Washington
667 Shreveport
405 White River Jct
554 Denver
622 Murfreesboro
656 St. Cloud
564 Fayetteville, AR
586 Jackson
438 Sioux Falls
645 Pittsburgh (HD)
631 Northampton
660 Salt Lake City
670 Syracuse
657 St. Louis
758 Las Vegas - IOC
693 Wilkes Barre
502 Alexandria
565 Fayetteville, NC
584 Iowa City
501 Albuquerque
678 Tucson
561 East Orange
619 Montgomery
508 Atlanta
674 Temple
592 Knoxville, IA

SERIOUSLY
DIFFICULT
(5.0 to 14.2)

402 Togus
630 New York
541 Cleveland
515 Battle Creek
590 Hampton
614 Memphis
662 San Francisco
460 Wilmington
641 Perry Point
685 Waco
691 Los Angeles
653 Roseburg
558 Durham
544 Columbia, SC
613 Martinsburg
652 Richmond
665 Sepulveda
552 Dayton
599 Livermore
680 Tuskegee
569 Fort Wayne
689 West Haven
663 Seattle
533 Castle Point
642 Philadelphia
568 Fort Meade
611 Marlin
617 Miles City
600 Long Beach
644 Phoenix
505 American Lake
757 Columbus - IOC
437 Fargo
655 Saginaw
608 Manchester
503 Altoona
649 Prescott
539 Cincinnati
509 Augusta
581 Huntington
629 New Orleans

SEVERELY
DIFFICULT
(14.3 to 34.0)

604 Lyons
512 Baltimore
526 Bronx
620 Montrose
566 Fort Howard
687 Walla Walla
627 Newington
519 Big Spring

LICENSED PRACTICAL NURSE

FAVORABLE
(-30.4 to 0)

584 Iowa City
586 Jackson
637 Asheville
518 Bedford
660 Salt Lake City
526 Bronx
757 Columbus - IOC
614 Memphis
460 Wilmington
531 Boise
671 San Antonio
519 Big Spring
436 Fort Harrison
583 Indianapolis
565 Fayetteville, NC
655 Saginaw
455 San Juan
657 St. Louis
562 Erie
595 Lebanon
641 Perry Point
678 Tucson
568 Fort Meade
605 Loma Linda
521 Birmingham
509 Augusta
676 Tomah
539 Cincinnati
594 Lake City
580 Houston
598 Little Rock
578 Hines
646 Pittsburgh (UD)
674 Temple
689 West Haven
501 Albuquerque
522 Bonham
549 Dallas
550 Danville
611 Marlin
636 Omaha
650 Providence
570 Fresno
670 Syracuse
513 Batavia
569 Fort Wayne
596 Lexington
663 Seattle
680 Tuskegee
623 Muskogee
442 Cheyenne
679 Tuscaloosa
647 Poplar Bluff
452 Wichita
543 Columbia, MO
621 Mountain Home
645 Pittsburgh (HD)
649 Prescott
667 Shreveport
437 Fargo
574 Grand Island
438 Sioux Falls
677 Topeka
512 Baltimore
529 Butler
540 Clarksburg
756 El Paso - IOC
758 Las Vegas - IOC
359 Honolulu

MODERATELY DIFFICULT
(0.1 to 10.1)

653 Roseburg
585 Iron Mountain
652 Richmond
658 Salem
544 Columbia, SC
695 Wood
520 Biloxi
504 Amarillo
528 Buffalo
626 Nashville
640 Palo Alto
508 Atlanta
553 Allen Park
516 Bay Pines
597 Lincoln
619 Montgomery
659 Salisbury
630 New York
537 Chicago (WS)
532 Canandaigua
538 Chillicothe
665 Sepulveda
517 Beckley
581 Huntington
673 Tampa
557 Dublin
573 Gainesville
558 Durham
579 Hot Springs
533 Castle Point
554 Denver
527 Brooklyn
642 Philadelphia
691 Los Angeles
607 Madison
627 Newington
685 Waco
564 Fayetteville, AR
693 Wilkes Barre
575 Grand Junction
589 Kansas City
561 East Orange
666 Sheridan
686 Leavenworth
668 Spokane

SERIOUSLY DIFFICULT
(11.1 to 37.1)

610 Marion, IN
506 Ann Arbor
541 Cleveland
603 Louisville
525 Brockton
664 San Diego
402 Togus
656 St. Cloud
500 Albany
590 Hampton
503 Altoona
618 Minneapolis
405 White River Jct.
514 Bath
591 Kerrville
567 Fort Lyon
502 Alexandria
612 Martinez
662 San Francisco
552 Dayton

SERIOUSLY DIFFICULT (cont'd.)

648 Portland
629 New Orleans
644 Phoenix
534 Charleston
505 American Lake
542 Coatesville
622 Murfreesboro
688 Washington
609 Marion, IL
600 Long Beach
555 Des Moines
617 Miles City
535 Chicago (LS)
608 Manchester
556 North Chicago

SEVERELY DIFFICULT
(43.0 to 140.0)

631 Northampton
523 Boston
515 Battle Creek
635 Oklahoma City
613 Martinsburg
654 Reno
632 Northport
592 Knoxville, IA
546 Miami
599 Livermore
566 Fort Howard
687 Walla Walla
604 Lyons
620 Montrose
692 White City

OCCUPATIONAL THERAPIST

FAVORABLE
(-100.0 to 0)

668 Spokane
569 Fort Wayne
597 Lincoln
579 Hot Springs
611 Marlin
607 Madison
678 Tucson
354 Honolulu
558 Durham
575 Grand Junction
543 Columbia, MO
532 Canandaigua
653 Roseburg
626 Nashville
644 Phoenix
537 Chicago (WS)
680 Tuskegee
679 Tuscaloosa
599 Livermore
583 Indianapolis
501 Albuquerque
691 Los Angeles
658 Salem
656 St. Cloud
509 Augusta
553 Allen Park
663 Seattle
598 Little Rock
618 Minneapolis
578 Hines
622 Murfreesboro
676 Tomah
542 Coatesville
554 Denver
455 San Juan
502 Alexandria
555 Des Moines
437 Fargo
623 Muskogee
539 Cincinnati
650 Providence
522 Bonham
686 Leavenworth
460 Wilmington
645 Pittsburgh (HD)
515 Battle Creek
608 Manchester
655 Saginaw
665 Sepulveda
521 Birmingham
581 Huntington
695 Wood
500 Albany
568 Fort Meade
670 Syracuse
534 Charleston
637 Asheville
603 Louisville
648 Portland
654 Reno
452 Wichita
612 Martinez
520 Biloxi
646 Pittsburgh (UD)
544 Columbia, SC
513 Batavia

FAVORABLE
(cont'd.)

664 San Diego
641 Perry Point
667 Shreveport
627 Newington
584 Iowa City
671 San Antonio
591 Kerrville
666 Sheridan
687 Walla Walla
692 White City
750 Boston
567 Fort Lyon
620 Montrose
586 Jackson
405 White River Jct
674 Temple
660 Salt Lake City
519 Big Spring
549 Dallas

MODERATELY DIFFICULT
(6.2 to 21.1)

592 Knoxville, IA
673 Tampa
652 Richmond
595 Lebanon
614 Memphis
600 Long Beach
677 Topeka
573 Gainesville
605 Loma Linda
528 Buffalo
640 Palo Alto
610 Marion, IN
531 Boise
402 Togus
685 Waco
580 Houston

SERIOUSLY DIFFICULT
(25.0 to 64.3)

636 Omaha
662 San Francisco
533 Castle Point
508 Atlanta
590 Hampton
541 Cleveland
689 West Haven
631 Northampton
505 American Lake
594 Lake City
527 Brooklyn
566 Fort Howard
529 Butler
642 Philadelphia
565 Fayetteville, NC
621 Mountain Home
659 Salisbury
516 Bay Pines
506 Ann Arbor
561 East Orange
523 Boston

SERIOUSLY DIFFICULT
(cont'd.)

514 Bath
556 North Chicago
557 Dublin
596 Lexington
525 Brockton
589 Kansas City
574 Grand Island

SEVERELY DIFFICULT
(70.0 to 172.2)

657 St. Louis
550 Danville
630 New York
629 New Orleans
526 Bronx
518 Bedford
540 Clarksburg
552 Dayton
538 Chillicothe
562 Erie
693 Wilkes Barre
632 Northport
546 Miami
613 Martinsburg
635 Oklahoma City
535 Chicago (LS)
649 Prescott
604 Lyons
438 Sioux Falls
688 Washington

PHARMACIST

FAVORABLE
(-54.3 to 0)

534 Charleston
653 Roseburg
752 Los Angeles - IOC
656 St. Cloud
363 Anchorage
654 Reno
686 Leavenworth
666 Sheridan
575 Grand Junction
610 Marion, IN
687 Walla Walla
520 Biloxi
635 Oklahoma City
504 Amarillo
562 Erie
674 Temple
521 Birmingham
460 Wilmington
539 Cincinnati
655 Saginaw
678 Tucson
538 Chillicothe
568 Fort Meade
550 Danville
359 Honolulu
622 Murfreesboro
509 Augusta
636 Omaha
567 Fort Lyon
552 Dayton
546 Miami
527 Brooklyn
556 North Chicago
437 Fargo
531 Boise
589 Kansas City
614 Memphis
549 Dallas
554 Denver
604 Lyons
629 New Orleans
595 Lebanon
525 Brockton
665 Sepulveda
607 Madison
515 Battle Creek
542 Coatesville
668 Spokane
609 Marion, IL
650 Providence
522 Bonham
569 Fort Wayne
438 Sioux Falls
585 Iron Mountain
503 Altoona
608 Manchester
597 Lincoln
581 Huntington
566 Fort Howard
677 Topeka
676 Tomah
452 Wichita
442 Cheyenne
631 Northampton
518 Bedford

FAVORABLE
(cont'd.)

514 Bath
591 Kerrville
611 Marlin
961 Beckley
647 Poplar Bluff
758 Las Vegas - IOC
621 Mountain Home
505 American Lake
692 White City
620 Montrose
630 New York
757 Columbus - IOC
599 Livermore

MODERATELY DIFFICULT
(0.4 to 18.9)

592 Knoxville, IA
523 Boston
590 Hampton
618 Minneapolis
578 Hines
455 San Juan
663 Seattle
526 Bronx
543 Columbia, MO
619 Montgomery
500 Albany
671 San Antonio
558 Durham
637 Asheville
512 Baltimore
667 Shreveport
598 Little Rock
662 San Francisco
596 Lexington
586 Jackson
645 Pittsburgh (HD)
658 Salem
756 El Paso - IOC
603 Louisville
580 Houston
540 Clarksburg
513 Batavia
405 White River Jct
664 San Diego
506 Ann Arbor
573 Gainesville
750 Boston - IOC
564 Fayetteville, AR
659 Salisbury
600 Long Beach
535 Chicago (LS)
533 Castle Point
688 Washington
693 Wilkes Barre
612 Martinez
519 Big Spring
557 Dublin
644 Phoenix
626 Nashville
541 Cleveland
436 Fort Harrison
537 Chicago (WS)

MODERATELY DIFFICULT
(cont'd.)

544 Columbia, SC
532 Canandaigua
642 Philadelphia
617 Miles City
685 Waco
583 Indianapolis
555 Des Moines
501 Albuquerque

SERIOUSLY DIFFICULT
(20.0 to 37.8)

679 Tuscaloosa
574 Grand Island
561 East Orange
627 Newington
584 Iowa City
570 Fresno
648 Portland
657 St. Louis
605 Loma Linda
640 Palo Alto
516 Bay Pines
553 Allen Park
502 Alexandria
565 Fayetteville, NC
402 Togus
623 Muskogee
579 Hot Springs
691 Los Angeles
529 Butler
680 Tuskegee
649 Prescott
528 Buffalo
660 Salt Lake City

SEVERELY DIFFICULT
(45.0 to 102.9)

689 West Haven
646 Pittsburgh (UD)
508 Atlanta
632 Northport
652 Richmond
670 Syracuse
695 Wood
641 Perry Point
594 Lake City
613 Martinsburg
673 Tampa

PHYSICAL THERAPIST

FAVORABLE
(-100.0 to 0)

504 Amarillo
645 Pittsburgh (HD)
611 Marlin
647 Poplar Bluff
692 White City
519 Big Spring
541 Cleveland
501 Albuquerque
505 American Lake
539 Cincinnati
575 Grand Junction
405 White River Jct
452 Wichita
614 Memphis
590 Hampton
598 Little Rock
654 Reno
677 Topeka
636 Omaha
518 Bedford
570 Fresno
500 Albany
543 Columbia, MO
662 San Francisco
402 Togus
555 Des Moines
635 Oklahoma City
542 Coatesville
437 Fargo
595 Lebanon
522 Bonham
569 Fort Wayne
589 Kansas City
532 Canandaigua
580 Houston
656 St. Cloud
604 Lyons
605 Loma Linda
564 Fayetteville, AR
436 Fort Harrison
568 Fort Meade
670 Syracuse
637 Ashville
680 Tuskegee
596 Lexington
574 Grand Island
562 Erie
653 Roseburg
573 Gainesville
520 Biloxi
558 Durham
685 Waco
664 San Diego
659 Salisbury
514 Bath
671 San Antonio
591 Kerrville
758 Las Vegas - IOC
666 Sheridan
687 Walla Walla
621 Mountain Home
586 Jackson
660 Salt Lake City
455 San Juan
750 Boston - IOC

MODERATELY DIFFICULT
(4.0 to 35.7)

695 Wood
693 Wilkes Barre
594 Lake City
552 Dayton
554 Denver
627 Newington
607 Madison
689 West Haven
508 Atlanta
648 Portland
665 Sepulveda
657 St. Louis
592 Knoxville, IA
523 Boston
546 Miami
673 Tampa
529 Butler
566 Fort Howard
544 Columbia, SC
513 Batavia
642 Philadelphia
533 Castle Point
632 Northport
528 Buffalo
691 Los Angeles
646 Pittsburgh (UD)
506 Ann Arbor
557 Dublin
613 Martinsburg
608 Manchester
521 Birmingham
597 Lincoln
676 Tomah
641 Perry Point
599 Livermore
674 Temple
600 Long Beach
663 Seattle

SERIOUSLY DIFFICULT
(38.8 to 66.7)

512 Baltimore
581 Huntington
617 Miles City
525 Brockton
509 Augusta
556 North Chicago
535 Chicago (LS)
640 Palo Alto
618 Minneapolis
578 Hines
650 Providence
359 Honolulu
652 Richmond
567 Fort Lyon
438 Sioux Falls
629 New Orleans
752 Los Angeles - IOC
561 East Orange
622 Murfreesboro
537 Chicago (WS)
757 Columbus - IOC
688 Washington

SERIOUSLY DIFFICULT
(cont'd.)

678 Tucson
503 Altoona
540 Clarksburg
502 Alexandria
668 Spokane
610 Marion, IN
526 Bronx
538 Chillicothe
534 Charleston
603 Louisville
515 Battlecreek
667 Shreveport
631 Northampton
626 Nashville
553 Allen Park

SEVERELY DIFFICULT
(73.8 to 150.0)

620 Montrose
550 Danville
531 Boise
623 Muskogee
679 Tuscaloosa
612 Martinez
658 Salem
516 Bay Pines
584 Iowa City
549 Dallas
630 New York
585 Iron Mountain
442 Cheyenne
565 Fayetteville, NC
527 Brooklyn
649 Prescott
583 Indianapolis
644 Phoenix

CERTIFIED/REGISTERED RESPIRATORY THERAPIST

FAVORABLE
(-100.0 to 0)

655 Saginaw
620 Montrose
629 New Orleans
591 Kerrville
649 Prescott
557 Dublin
564 Fayetteville, AR
513 Batavia
514 Bath
508 Atlanta
594 Lake City
509 Augusta
512 Baltimore
438 Sioux Falls
622 Murfreesboro
539 Cincinnati
656 St. Cloud
504 Amarillo
693 Wilkes Barre
570 Fresno
555 Des Moines
585 Iron Mountain
604 Lyons
520 Biloxi
553 Allen Park
455 San Juan
590 Hampton
534 Charleston
637 Asheville
670 Syracuse
500 Albany
636 Omaha
527 Brooklyn
659 Salisbury
437 Fargo
695 Wood
595 Lebanon
673 Tampa
688 Washington
516 Bay Pines
596 Lexington
537 Chicago (WS)
668 Spokane
522 Bonham
658 Salem
540 Clarksburg
686 Leavenworth
610 Marion, IN
552 Dayton
550 Danville
589 Kansas City
580 Houston
503 Altoona
526 Bronx
614 Memphis
597 Lincoln
581 Huntington
538 Chillicothe
579 Hot Springs
677 Topeka
618 Minneapolis
676 Tomah
568 Fort Meade
529 Butler
603 Louisville
648 Portland

FAVORABLE
(cont'd.)

654 Reno
607 Madison
501 Albuquerque
574 Grand Island
562 Erie
653 Roseburg
452 Wichita
612 Martinez
646 Pittsburgh (UD)
554 Denver
642 Philadelphia
641 Perry Point
565 Fayetteville, NC
631 Northampton
635 Oklahoma City
647 Poplar Bluff
687 Walla Walla
621 Mountain Home
505 American Lake
586 Jackson
405 White River Jct
674 Temple
402 Togus
549 Dallas
592 Knoxville, IA
561 East Orange

MODERATELY DIFFICULT
(2.2 to 23.1)

652 Richmond
535 Chicago (LS)
600 Long Beach
542 Coatesville
598 Little Rock
667 Shreveport
660 Salt Lake City
543 Columbia, MO
613 Martinsburg
556 North Chicago
521 Birmingham
584 Iowa City
691 Los Angeles
665 Sepulveda
525 Brockton
573 Gainesville
644 Phoenix
666 Sheridan

SERIOUSLY DIFFICULT
(27.1 to 43.7)

523 Boston
608 Manchester
657 St. Louis
630 New York
605 Loma Linda
558 Durham
583 Indianapolis
626 Nashville
575 Grand Junction
609 Marion, IL
678 Tucson
518 Bedford
662 San Francisco
627 Newington
663 Seattle

SEVERELY DIFFICULT
(50.0 to 150.0)

502 Alexandria
650 Providence
671 San Antonio
689 West Haven
578 Hines
546 Miami
528 Buffalo
506 Ann Arbor
664 San Diego
531 Boise
566 Fort Howard
541 Cleveland
569 Fort Wayne
544 Columbia, SC
436 Ft. Harrison
599 Livermore
632 Northport
640 Palo Alto
617 Miles City

DIAGNOSTIC RADIOLOGIC TECHNICIANS/TECHNOLOGISTS

FAVORABLE
(-66.7 to 0.0)

562 Erie
653 Roseburg
677 Topeka
595 Lebanon
505 American Lake
533 Castle Point
594 Lake City
526 Bronx
555 Des Moines
521 Birmingham
609 Marion, IL
693 Wilkes Barre
626 Nashville
640 Palo Alto
502 Alexandria
506 Ann Arbor
437 Fargo
622 Murfreesboro
438 Sioux Falls
671 San Antonio
618 Minneapolis
659 Salisbury
665 Sepulveda
565 Fayetteville, NC
590 Hampton
573 Gainesville
646 Pittsburgh (UD)
670 Syracuse
667 Shreveport
608 Manchester
531 Boise
596 Lexington
558 Durham
516 Bay Pines
678 Tucson
635 Oklahoma City
636 Omaha
598 Little Rock
537 Chicago (WS)
460 Wilmington
575 Grand Junction
750 Boston - IOC
504 Amarillo
657 St. Louis
619 Montgomery
517 Beckley
666 Sheridan
539 Cincinnati
658 Salem
528 Buffalo
676 Tomah
402 Togus
542 Coatesville
668 Spokane
543 Columbia, MO
522 Bonham
569 Fort Wayne
686 Leavenworth
610 Marion, IN
645 Pittsburgh (HD)
515 Battle Creek
756 El Paso - IOC
532 Canandaigua
649 Prescott
585 Iron Mountain
503 Altoona
656 St. Cloud
597 Lincoln
538 Chillicothe

FAVORABLE
(cont'd.)

566 Fort Howard
564 Fayetteville, AR
436 Fort Harrison
617 Miles City
534 Charleston
680 Tuskegee
679 Tuscaloosa
654 Reno
607 Madison
452 Wichita
442 Cheyenne
508 Atlanta
513 Batavia
673 Tampa
570 Fresno
655 Saginaw
641 Perry Point
631 Northampton
514 Bath
591 Kerrville
688 Washington
611 Marlin
647 Poplar Bluff
758 Las Vegas - IOC
687 Walla Walla
692 White City
567 Fort Lyon
359 Honolulu
405 White River Jct
757 Columbus - IOC
599 Livermore
674 Temple
519 Big Spring
549 Dallas

MODERATELY DIFFICULT
(0.2 TO 9.3)

578 Hines
630 New York
605 Loma Linda
552 Dayton
580 Houston
648 Portland
685 Waco
589 Kansas City
586 Jackson
512 Baltimore
455 San Juan
546 Miami
501 Albuquerque
553 Allen Park
621 Mountain Home
614 Memphis
520 Biloxi
612 Martinez
629 New Orleans

SERIOUSLY DIFFICULT
(10.1 to 21.4)

544 Columbia, SC
541 Cleveland
583 Indianapolis
535 Chicago (LS)
652 Richmond
650 Providence
603 Louisville
557 Dublin
529 Butler
556 North Chicago
584 Iowa City
509 Augusta
642 Philadelphia
500 Albany
637 Asheville
644 Phoenix
518 Bedford
632 Northport
695 Wood
623 Muskogee

SEVERELY DIFFICULT
(22.0 to 93.3)

663 Seattle
613 Martinsburg
527 Brooklyn
664 San Diego
561 East Orange
604 Lyons
752 Los Angeles - IOC
620 Montrose
660 Salt Lake City
540 Clarksburg
691 Los Angeles
579 Hot Springs
574 Grand Island
554 Denver
662 San Francisco
525 Brockton
523 Boston
568 Fort Meade
600 Long Beach
592 Knoxville, IA
689 West Haven
627 Newington

THERAPEUTIC RADIOLOGIC TECHNICIAN/TECHNOLOGIST

FAVORABLE (-100.0 to 0.0)	MODERATELY DIFFICULT (15.5 to 25.0)	SERIOUSLY DIFFICULT (33.3 to 36.7)	SEVERELY DIFFICULT (50.0 to 150.0)
556 North Chicago	695 Wood	691 Los Angeles	561 East Orange
535 Chicago (LS)	526 Bronx	578 Hines	632 Northport
612 Martinez			546 Miami
580 Houston			500 Albany
614 Memphis			527 Brooklyn
553 Allen Park			
541 Cleveland			
664 San Diego			
688 Washington			
689 West Haven			
618 Minneapolis			
523 Boston			
508 Atlanta			
528 Buffalo			
600 Long Beach			
455 San Juan			
549 Dallas			

DENTAL ASSISTANT

FAVORABLE
(-68.7 to 0.0)

757 Columbus - IOC
692 White City
623 Muskogee
555 Des Moines
518 Bedford
614 Memphis
594 Lake City
532 Canandaigua
514 Bath
632 Northport
610 Marion, IN
570 Fresno
618 Minneapolis
622 Murfreesboro
526 Bronx
561 East Orange
578 Hines
554 Denver
596 Lexington
626 Nashville
648 Portland
537 Chicago (WS)
580 Houston
629 New Orleans
605 Loma Linda
652 Richmond
528 Buffalo
657 St. Louis
630 New York
521 Birmingham
660 Salt Lake City
558 Durham
671 San Antonio
550 Danville
504 Amarillo
590 Hampton
529 Butler
584 Iowa City
517 Beckley
566 Fort Howard
531 Boise
506 Ann Arbor
515 Battle Creek
505 American Lake
542 Coatesville
502 Alexandria
575 Grand Junction
557 Dublin
516 Bay Pines
668 Spokane
543 Columbia, MO
609 Marion, IL
539 Cincinnati
650 Providence
595 Lebanon
522 Bonham
569 Fort Wayne
658 Salem
540 Clarksburg
686 Leavenworth
460 Wilmington
645 Pittsburgh (HD)
552 Dayton
438 Sioux Falls
649 Prescott
585 Iron Mountain
503 Altoona
656 St. Cloud
613 Martinsburg
583 Indianapolis
556 North Chicago
597 Lincoln
581 Huntington

FAVORABLE
(cont'd.)

538 Chillicothe
695 Wood
564 Fayetteville, AR
579 Hot Springs
677 Topeka
436 Fort Harrison
676 Tomah
617 Miles City
568 Fort Meade
534 Charleston
603 Louisville
636 Omaha
654 Reno
607 Madison
574 Grand Island
562 Erie
452 Wichita
612 Martinez
520 Biloxi
640 Palo Alto
442 Cheyenne
508 Atlanta
685 Waco
513 Batavia
673 Tampa
655 Saginaw
641 Perry Point
635 Oklahoma City
565 Fayetteville, NC
627 Newington
631 Northampton
591 Kerrville
611 Marlin
647 Poplar Bluff
666 Sheridan
687 Walla Walla
678 Tucson
621 Mountain Home
567 Fort Lyon
359 Honolulu
586 Jackson
405 White River Jct
599 Livermore
533 Castle Point
674 Temple
402 Togus
455 San Juan
519 Big Spring
549 Dallas
592 Knoxville, IA

MODERATELY
DIFFICULT
(3.4 to 12.5)

541 Cleveland
573 Gainesville
750 Boston - IOC
604 Lyons
646 Pittsburgh (UD)
688 Washington
670 Syracuse
619 Montgomery
752 Los Angeles - IOC
664 San Diego
553 Allen Park

SERIOUSLY
DIFFICULT
(13.1 to 26.8)

527 Brooklyn
509 Augusta
546 Miami
600 Long Beach
512 Baltimore
500 Albany
501 Albuquerque
642 Philadelphia
680 Tuskegee
691 Los Angeles
679 Tuscaloosa
544 Columbia, SC
659 Salisbury
644 Phoenix
589 Kansas City
665 Sepulveda
598 Little Rock
693 Wilkes Barre

SEVERELY
DIFFICULT
(30.0 to 68.6)

653 Roseburg
662 San Francisco
437 Fargo
535 Chicago (LS)
758 Las Vegas - IOC
663 Seattle
608 Manchester
667 Shreveport
620 Montrose
637 Ashville
525 Brockton
689 West Haven
756 El Paso - IOC
523 Boston

DENTAL HYGIENIST

FAVORABLE
(-133.3 to 0.0)

520 Biloxi
641 Perry Point
660 Salt Lake City
678 Tucson
542 Coatesville
604 Lyons
693 Wilkes Barre
673 Tampa
525 Brockton
550 Danville
756 El Paso - IOC
750 Boston - IOC
504 Amarillo
590 Hampton
605 Loma Linda
630 New York
568 Fort Meade
529 Butler
574 Grand Island
584 Iowa City
692 White City
592 Knoxville
515 Battle Creek
502 Alexandria
557 Dublin
509 Augusta
516 Bay Pines
668 Spokane
543 Columbia, MO
609 Marion, IL
539 Cincinnati
650 Providence
595 Lebanon
540 Clarksburg
537 Chicago (WS)
610 Marion, IN
460 Wilmington
552 Dayton
594 Lake City
527 Brooklyn
589 Kansas City
532 Canandaigua
598 Little Rock
580 Houston
503 Altoona
656 St. Cloud
613 Martinsburg
526 Bronx
608 Manchester
614 Memphis
583 Indianapolis
556 North Chicago
521 Birmingham
597 Lincoln
657 St. Louis
538 Chillicothe
546 Miami
752 Los Angeles - IOC
695 Wood
566 Fort Howard
564 Fayetteville, AR
500 Albany
579 Hot Springs
436 Fort Harrison
618 Minneapolis
670 Syracuse
534 Charleston
637 Ashville
561 East Orange
603 Louisville

FAVORABLE
(cont'd.)

680 Tuskegee
691 Los Angeles
636 Omaha
679 Tuscaloosa
648 Portland
596 Lexington
578 Hines
607 Madison
562 Erie
452 Wichita
573 Gainesville
523 Boston
558 Durham
640 Palo Alto
442 Cheyenne
508 Atlanta
685 Waco
513 Batavia
646 Pittsburgh (UD)
570 Fresno
655 Saginaw
541 Cleveland
664 San Diego
662 San Francisco
667 Shreveport
635 Oklahoma City
565 Fayetteville, NC
627 Newington
631 Northampton
659 Salisbury
671 San Antonio
528 Buffalo
591 Kerrville
758 Las Vegas - IOC
666 Sheridan
626 Nashville
644 Phoenix
621 Mountain Home
663 Seattle
600 Long Beach
620 Montrose
586 Jackson
405 White River Jct
575 Columbus - IOC
533 Castle Point
674 Temple
402 Togus
455 San Juan
519 Big Spring
549 Dallas
506 Ann Arbor

MODERATELY DIFFICULT
(11.1 to 12.5)

619 Montgomery
632 Northport

SERIOUSLY DIFFICULT
(50.0)

665 Sepulveda
501 Albuquerque
642 Philadelphia
652 Richmond
688 Washington

SEVERELY DIFFICULT
(80.0 to 100.0)

518 Bedford
645 Pittsburgh (HD)
535 Chicago (LS)
581 Huntington
629 New Orleans
544 Columbia, SC
623 Muskogee
612 Martinez
554 Denver
622 Murfreesboro

ECHOCARDIOGRAPH TECHNICIAN

FAVORABLE
(-100.0 to 0.0)

526 Bronx
608 Manchester
544 Columbia, SC
630 New York
509 Augusta
516 Bay Pines
623 Muskogee
543 Columbia, MO
650 Providence
636 Omaha
531 Boise
527 Brooklyn
540 Clarksburg
626 Nashville
756 El Paso - IOC
561 East Orange
501 Albuquerque
667 Shreveport
598 Little Rock
580 Houston
614 Memphis
583 Indianapolis
665 Sepulveda
605 Loma Linda
657 St. Louis
546 Miami
695 Wood
689 West Haven
579 Hot Springs
618 Minneapolis
534 Charleston
691 Los Angeles
654 Reno
596 Lexington
578 Hines
562 Erie
452 Wichita
573 Gainesville
523 Boston
558 Durham
693 Wilkes Barre
508 Atlanta
673 Tampa
541 Cleveland
652 Richmond
662 San Francisco
528 Buffalo
584 Iowa City
518 Bedford
663 Seattle
600 Long Beach
405 White River Jct
525 Brockton
660 Salt Lake City
553 Allen Park
455 San Juan
549 Dallas

MODERATELY DIFFICULT
(15.4)

688 Washington

SEVERELY DIFFICULT
(45.0 to 100.0)

612 Martinez
550 Danville
648 Portland
590 Hampton
554 Denver

NUCLEAR MEDICINE TECHNICIAN

FAVORABLE
(-100.0)

561 E. Orange
501 Albuquerque
659 Salisbury
597 Lincoln
518 Bedford
673 Tampa
575 Grand Junction
609 Marion, IL
525 Brockton
523 Boston
658 Salem
531 Boise
402 Togus
452 Wichita
540 Clarksburg
537 Chicago (WS)
504 Amarillo
590 Hampton
693 Wilkes Barre
667 Shreveport
600 Long Beach
542 Coatesville
557 Dublin
509 Augusta
512 Baltimore
437 Fargo
516 Bay Pines
623 Muskogee
668 Spokane
650 Providence
569 Fort Wayne
686 Leavenworth
552 Dayton
550 Danville
527 Brooklyn
589 Kansas City
598 Little Rock
649 Prescott
613 Martinsburg
526 Bronx
608 Manchester
614 Memphis
583 Indianapolis
665 Sepulveda
581 Huntington
629 New Orleans
546 Miami
695 Wood
689 West Haven
566 Fort Howard
618 Minneapolis
670 Syracuse
534 Charleston
637 Asheville
680 Tuskegee
691 Los Angeles
636 Omaha
535 Chicago (LS)
648 Portland
596 Lexington
607 Madison
573 Gainesville

FAVORABLE
(cont'd.)

520 Biloxi
544 Columbia, SC
442 Cheyenne
554 Denver
513 Batavia
570 Fresno
642 Philadelphia
641 Perry Point
662 San Francisco
528 Buffalo
565 Fayetteville, NC
627 [illegible]
671 San Antonio
647 Poplar Bluff
621 Mountain Home
505 American Lake
663 Seattle
620 Montrose
622 Murfreesboro
586 Jackson
405 White River Jct
590 Livermore
660 Salt Lake City
553 Allen Park
455 San Juan
519 Big Spring
506 Ann Arbor

MODERATELY DIFFICULT
(12.5 to 16.6)

549 Dallas
640 Palo Alto
688 Washington

SERIOUSLY DIFFICULT
(25.0 to 36.7)

558 Durham
664 San Diego
605 Loma Linda
657 St. Louis

SEVERELY DIFFICULT
(50.0 to 150.0)

502 Alexandria
580 Houston
654 Reno
555 Des Moines
460 Wilmington
652 Richmond
603 Louisville

NUCLEAR MEDICINE TECHNOLOGIST

FAVORABLE (-100.0 to 0.0)

512 Baltimore
460 Wilmington
677 Topeka
612 Matinez
570 Fresno
580 Houston
556 North Chicago
526 Bronx
520 Biloxi
693 Wilkes Barre
501 Albuquerque
584 Iowa City
553 Allen Park
626 Nashville
528 Buffalo
578 Hines
516 Bay Pines
537 Chicago (WS)
590 Hampton
630 New York
561 East Orange
667 Shreveport
591 Kerrville
688 Washington
517 Beckley
542 Coatesville
509 Augusta
437 Fargo
539 Cincinnati
650 Providence
552 Dayton
550 Danville
527 Brooklyn
598 Little Rock
438 Sioux Falls
585 Iron Mountain
614 Memphis
583 Indianapolis
604 Lyons
521 Birmingham
581 Huntington
605 Loma Linda
629 New Orleans
546 Miami
695 Wood
500 Albany
579 Hot Springs
618 Minneapolis
670 Syracuse
637 Asheville
603 Louisville
680 Tuskegee
636 Omaha
535 Chicago (LS)
648 Portland
596 Lexington
607 Madison
653 Roseburg
523 Boston
558 Durham
508 Atlanta
541 Cleveland

FAVORABLE (cont'd.)

635 Oklahoma City
565 Fayetteville, NC
671 San Antonio
644 Phoenix
678 Tucson
620 Montrose
405 White River Jct
525 Brockton
660 Salt Lake City
455 San Juan
549 Dallas
506 Ann Arbor

MODERATELY DIFFICULT (16.7 to 45.0)

652 Richmond
673 Tampa
691 Los Angeles

SEVERELY DIFFICULT (50.0 to 100.0)

613 Martinsburg
632 Northport
543 Columbia, MO
657 St. Louis
608 Manchester

OPHTHALMOLOGIST TECHNICIAN

FAVORABLE
(-100.0 to 0.0)

636 Omaha
648 Portland
626 Nashville
663 Seattle
539 Cincinnati
516 Bay Pines
543 Columbia, MO
552 Dayton
589 Kansas City
555 Des Moines
598 Little Rock
580 Houston
556 North Chicago
665 Sepulveda
521 Birmingham
590 Hampton
657 St. Louis
546 Miami
561 East Orange
680 Tuskegee
658 Salem
596 Lexington
607 Madison
501 Albuquerque
573 Gainesville
612 Martinez
520 Biloxi
558 Durham
554 Denver
508 Atlanta
673 Tampa
652 Richmond
635 Oklahoma City
528 Buffalo
591 Kerrville
678 Tucson
600 Long Beach
586 Jackson
674 Temple
402 Togus
455 San Juan
519 Big Spring
549 Dallas

SEVERELY
DIFFICULT
(50.0 to 150.0)

644 Phoenix
509 Augusta
691 Los Angeles
544 Columbia, SC
642 Philadelphia
689 West Haven
671 San Antonio

PULMONARY FUNCTION TECHNICIAN

FAVORABLE
(-100.0 to 0.0)

561 East Orange
598 Little Rock
578 Hines
550 Danville
648 Portland
525 Brockton
652 Richmond
618 Minneapolis
540 Clarksburg
537 Chicago (WS)
614 Memphis
665 Sepulveda
564 Fayetteville
452 Wichita
646 Pittsburgh (UD)
541 Cleveland
662 San Francisco
660 Salt Lake City
517 Beckley
509 Augusta
623 Muskogee
543 Columbia, MO
539 Cincinnati
650 Providence
595 Lebanon
658 Salem
686 Leavenworth
460 Wilmington
552 Dayton
531 Boise
535 Chicago (LS)
594 Lake City
527 Brooklyn
589 Kansas City
555 Des Moines
649 Prescott
580 Houston
503 Altoona
526 Bronx
583 Indianapolis
556 North Chicago
521 Birmingham
581 Huntington
605 Loma Linda
546 Miami
695 Wood
689 West Haven
677 Topeka
436 Fort Harrison
676 Tomah
670 Syracuse
534 Charleston
637 Asheville
680 Tuskegee
691 Los Angeles
636 Omaha
679 Tuscaloosa
654 Reno
596 Lexington
607 Madison
501 Albuquerque
574 Grand Island

FAVORABLE
(cont'd.)

573 Gainesville
612 Martinez
523 Boston
544 Columbia, SC
558 Durham
554 Denver
508 Atlanta
685 Waco
693 Wilkes Barre
570 Fresno
642 Philadelphia
664 San Diego
667 Shreveport
528 Buffalo
631 Northampton
635 Oklahoma City
584 Iowa City
671 San Antonio
688 Washington
644 Phoenix
678 Tucson
505 American Lake
663 Seattle
600 Long Beach
586 Jackson
632 Northport
402 Togus
553 Allen Park
455 San Juan
549 Dallas

MODERATELY DIFFICULT
(9.1 to 31.0)

512 Baltimore
500 Albany
657 St. Louis

SEVERELY DIFFICULT
(50.0 to 325.0)

630 New York
640 Palo Alto
604 Lyons
590 Hampton
673 Tampa

CHAPTER 30 TRAINEES BY STATE, FY1986 ACTUAL AND ESTIMATED FY1987 + FY1988

fiscal year	1986	1987	1988
Alabama			542
Alaska			91
Arizona			462
Arkansas			208
California			2,710
Colorado			489
Connecticut			144
Delaware			45
District of Columbia			116
Florida			1,122
Georgia			574
Hawaii			206
Idaho			96
Illinois			568
Indiana			329
Iowa			136
Kansas			237
Kentucky			258
Louisiana			328
Maine			101
Maryland			478
Massachusetts			301
Michigan			423
Minnesota			263
Mississippi			151
Missouri			435
Montana			75
Nebraska			187
Nevada			134
New Hampshire			101
New Jersey			217
New Mexico			199
New York			567
North Carolina			589
North Dakoka			72
Ohio			581

Oklahoma			409
Oregon			253
Pennsylvania			541
Rhode Island			81
South Carolina			417
South Dakota			67
Tennessee			356
Texas			1,763
Utah			126
Vermont			19
Virginia			725
Washington			642
West Virginia			93
Wisconsin			246
Wyoming			54
Puerto Rico			70
TOTAL US,PR	*1	**800	19,400

*TRAINED IN NORTH CAROLINA
**NO ASSUMPTIONS ARE MADE AS TO DISTRIBUTION OF THE 800 TRAINEES DUE TO NO SIGNIFICANT PRIOR YEAR ACTUALS

CHAPTER 31 TRAINEES

	FY 1986	FY 1987	FY 1988
Alabama	837	821	805
Alaska	36	35	34
Arizona	707	686	672
Arkansas	342	331	325
California	1,679	1,628	1,596
Colorado	570	553	542
Connecticut	208	202	198
Delaware	142	138	135
District of Columbia	106	103	101
Florida	352	341	334
Georgia	509	494	484
Hawaii	115	111	109
Idaho	138	134	132
Illinois	554	537	526
Indiana	802	778	762
Iowa	336	325	319
Kansas	337	327	320
Kentucky	528	512	501
Louisiana	395	383	376
Maine	258	250	245
Maryland	475	461	452
Massachusetts	399	387	379
Michigan	758	736	721
Minnesota	432	419	410
Mississippi	304	295	289
Missouri	364	353	346

Montana	127	123	121
Nebraska	143	139	136
Nevada	311	301	295
New Hampshire	208	202	198
New Jersey	655	635	622
New Mexico	306	296	290
New York	964	935	916
North Carolina	730	708	694
North Dakota	95	92	90
Ohio	954	925	907
Oklahoma	695	674	660
Oregon	645	625	613
Pennsylvania	1,081	1,049	1,028
Puerto Rico	464	450	441
Rhode Island	140	135	133
South Carolina	389	377	370
South Dakota	244	237	232
Tennessee	690	669	656
Texas	2,294	2,225	2,180
Utah	272	264	258
Vermont	116	113	110
Virginia	801	777	761
Washington	735	713	698
West Virginia	273	265	260
Wisconsin	687	667	653
Wyoming	65	63	62
TOTALS	25,777	25,000	24,501

CHAPTER 34 TRAINEES BY STATE, FY1986 ACTUAL AND
ESTIMATED FY1987, 1988

fiscal year	1986	1987	1988
Alabama	8,544	6,488	5,080
Alaska	1,442	1,095	857
Arizona	7,282	5,530	4,329
Arkansas	3,278	2,489	1,949
California	42,713	32,434	25,395
Colorado	7,712	5,856	4,585
Connecticut	2,268	1,722	1,348
Delaware	711	540	423
District of Columbia	1,828	1,388	1,087
Florida	17,685	13,429	10,515
Georgia	9,051	6,873	5,381
Hawaii	3,248	2,466	1,931
Idaho	1,511	1,147	898
Illinois	8,955	6,800	5,324
Indiana	5,187	3,939	3,084
Iowa	2,137	1,623	1,271
Kansas	3,731	2,833	2,218
Kentucky	4,064	3,086	2,416
Louisiana	5,172	3,927	3,075
Maine	1,587	1,205	944
Maryland	7,527	5,716	4,475
Massachusetts	4,748	3,605	2,823
Michigan	6,668	5,063	3,964
Minnesota	4,145	3,148	2,464
Mississippi	2,382	1,809	1,416
Missouri	6,850	5,202	4,073
Montana	1,179	895	702
Nebraska	2,943	2,235	1,750
Nevada	2,115	1,606	1,257
New Hampshire	1,587	1,205	944
New Jersey	3,420	2,597	2,033
New Mexico	3,133	2,379	1,863
New York	8,940	6,789	5,315
North Carolina	9,289	7,054	5,523
North Dakoka	1,134	861	674
Ohio	9,164	6,959	5,448
Oklahoma	6,452	4,899	3,836

Oregon	3.995	3,034	2,375
Pennsylvania	8,526	6,474	5,069
Rhode Island	1,278	970	760
South Carolina	6.572	4,990	3,907
South Dakota	1,057	803	628
Tennessee	5.614	4,263	3.338
Texas	27,780	21,095	16.517
Utah	1.992	1,513	1,184
Vermont	307	233	184
Virginia	11,424	8,675	6,792
Washington	10,119	7.684	6,016
West Virginia	1.470	1,116	874
Wisconsin	3.881	2,947	2,307
Wyoming	847	643	504
Puerto Rico	1.110	843	660
TOTAL US.PR	305,754	232,175	181.785

CHAPTER 35 TRAINEES BY STATE, FY1986 ACTUAL
AND ESTIMATED FY1987, 1988

fiscal year	1986	1987	1988
Alabama	1,679	1,498	1,340
Alaska	74	66	59
Arizona	1,260	1,124	1,006
Arkansas	947	845	756
California	4,980	4443	3975
Colorado	975	870	778
Connecticut	291	260	232
Delaware	122	109	97
District of Columbia .	220	196	176
Florida	3,725	3,324	2,974
Georgia	1,821	1,625	1,454
Hawaii	272	243	217
Idaho	222	198	177
Illinois	915	817	731
Indiana	798	712	637
Iowa	357	319	285
Kansas	532	475	425
Kentucky	1,034	923	826
Louisiana	968	864	773
Maine	298	266	238
Maryland	810	723	647
Massachusetts	1,304	1,164	1,041
Michigan	1,216	1,085	971
Minnesota	597	533	477
Mississippi	663	592	529
Missouri	869	775	694
Montana	170	152	136
Nebraska	404	361	323
Nevada	203	181	162
New Hampshire	210	187	168
New Jersey	672	600	537
New Mexico	553	493	441
New York	2,163	1,930	1,727
North Carolina	2,178	1,944	1,739
North Dakoka	111	99	89
Ohio	1,380	1,232	1,102

Oklahoma	1.418	1,265	1,132
Oregon	497	444	397
Pennsylvania	1,529	1,364	1,221
Rhode Island	289	258	231
South Carolina	1,077	961	860
South Dakota	161	144	129
Tennessee	1.156	1,032	923
Texas	5,027	4485	4012
Utah	426	380	340
Vermont	104	93	83
Virginia	2,008	1,792	1,603
Washington	1,388	1,239	1,108
West Virginia	431	385	344
Wisconsin	712	635	568
Wyoming	112	100	89
Puerto Rico	1611	1.438	1,286
TOTAL US.PR	52,939	47,243	42,265

CHAPTER 106 TRAINEES

	FY 1986	FY 1987	FY 1988
Alabama	1,758	4,873	6,860
Alaska	32	88	124
Arizona	460	1,273	1,792
Arkansas	763	2,115	2,978
California	1,550	4,293	6,044
Colorado	218	605	853
Connecticut	336	930	1,310
Delaware	99	272	383
District of Columbia	182	500	705
Florida	654	1,809	2,545
Georgia	480	1,335	1,878
Hawaii	137	378	530
Idaho	304	843	1,187
Illinois	1,396	3,872	5,450
Indiana	644	1,782	2,508
Iowa	613	1,703	2,398
Kansas	534	1,484	2,088
Kentucky	576	1,598	2,250
Louisiana	1,054	2,924	4,115
Maine	191	527	742
Maryland	246	685	964
Massachusetts	741	2,055	2,892
Michigan	629	1,747	2,460
Minnesota	775	2,150	3,028
Mississippi	670	1,860	2,620
Missouri	941	2,608	3,670

Montana	342	948	1,335
Nebraska	929	2,573	3,620
Nevada	133	369	519
New Hampshire	93	255	358
New Jersey	271	755	1,063
New Mexico	192	535	754
New York	855	2,370	3,337
North Carolina	611	1,695	2,385
North Dakota	744	2,063	2,905
Ohio	2,305	6,392	8,998
Oklahoma	839	2,325	3,275
Oregon	451	1,247	1,755
Pennsylvania	846	2,344	3,300
Puerto Rico	320	887	1,248
Rhode Island	265	738	1,038
South Carolina	784	2,169	3,053
South Dakota	350	965	1,360
Tennessee	694	1,923	2,707
Texas	1,273	3,530	4,968
Utah	818	2,265	3,188
Vermont	51	140	198
Virginia	398	1,105	1,557
Washington	681	1,888	2,657
West Virginia	337	930	1,310
Wisconsin	945	2,615	3,683
Wyoming	169	465	655
TOTALS	31,678	87,800	123,600

CHAPTER 34 & 35
ACTIVE INSTITUTIONS & ESTABLISHMENTS
EOM OCTOBER 1985

	IHL	NCD	OJT
Alabama	77	61	78
Alaska	18	8	16
Arizona	50	55	52
Arkansas	38	59	42
California	372	227	250
Colorado	57	31	51
Connecticut	47	25	55
Delaware	14	8	6
District of Columbia	27	7	10
Florida	120	110	131
Georgia	91	61	117
Hawaii	21	9	11
Idaho	14	10	16
Illinois	160	42	67
Indiana	56	39	83
Iowa	69	13	19
Kansas	57	28	25
Kentucky	68	49	48
Louisiana	43	88	92
Maine	36	32	37
Maryland	65	42	57
Massachusetts	107	45	82
Michigan	99	56	70
Minnesota	81	62	70
Mississippi	44	17	15
Missouri	119	95	71

Montana	14	12	33
Nebraska	34	12	37
Nevada	13	10	16
New Hampshire	28	9	39
New Jersey	73	64	76
New Mexico	27	13	16
New York	297	103	189
North Carolina	149	20	81
North Dakota	20	6	24
Ohio	137	65	129
Oklahoma	53	72	48
Oregon	51	27	60
Pennsylvania	254	101	152
Puerto Rico	51	37	0
Rhode Island	13	11	9
South Carolina	69	28	124
South Dakota	24	13	69
Tennessee	93	74	61
Texas	208	104	142
Utah	20	15	21
Vermont	16	2	46
Virginia	94	64	76
Washington	72	40	99
West Virginia	40	39	38
Wisconsin	84	11	111
Wyoming	10	8	29
TOTALS	3,894	2,239	3,296

CHAPTER 34 & 35
ACTIVE INSTITUTIONS & ESTABLISHMENTS
EOM OCTOBER 1986

	IHL	NCD	OJT
Alabama	74	53	36
Alaska	16	11	6
Arizona	52	41	37
Arkansas	40	59	23
California	350	175	207
Colorado	60	26	46
Connecticut	45	27	43
Delaware	13	5	3
District of Columbia	23	6	9
Florida	115	90	96
Georgia	92	52	86
Hawaii	21	12	12
Idaho	15	6	13
Illinois	145	34	54
Indiana	53	20	55
Iowa	60	10	11
Kansas	53	32	8
Kentucky	66	41	35
Louisiana	42	93	56
Maine	35	21	35
Maryland	61	36	40
Massachusetts	90	32	64
Michigan	92	43	54
Minnesota	73	56	50
Mississippi	45	13	9
Missouri	115	87	44

Montana	12	13	23
Nebraska	33	13	23
Nevada	13	9	9
New Hampshire	27	9	29
New Jersey	68	64	52
New Mexico	27	14	13
New York	277	89	131
North Carolina	139	17	56
North Dakota	19	3	10
Ohio	129	54	85
Oklahoma	50	70	36
Oregon	47	21	44
Pennsylvania	236	85	101
Puerto Rico	48	30	0
Rhode Island	13	11	8
South Carolina	64	14	98
South Dakota	20	11	42
Tennessee	81	58	45
Texas	211	93	85
Utah	22	13	7
Vermont	17	4	33
Virginia	95	56	60
Washington	74	26	81
West Virginia	41	26	26
Wisconsin	85	5	80
Wyoming	12	6	16
TOTALS	3,706	1,895	2,325

CHAPTER 34 & 35
ACTIVE INSTITUTIONS & ESTABLISHMENTS
EOM OCTOBER 1987

	IHL	NCD	OJT
Alabama	70	45	25
Alaska	15	9	4
Arizona	49	35	26
Arkansas	38	50	16
California	332	149	147
Colorado	57	22	33
Connecticut	43	23	30
Delaware	12	4	2
District of Columbia	22	5	6
Florida	109	76	68
Georgia	87	44	61
Hawaii	20	10	8
Idaho	14	5	9
Illinois	137	29	38
Indiana	50	17	39
Iowa	57	8	8
Kansas	50	27	6
Kentucky	63	35	25
Louisiana	40	79	40
Maine	33	18	25
Maryland	58	30	28
Massachusetts	85	27	45
Michigan	87	36	38
Minnesota	69	48	35
Mississippi	43	11	6
Missouri	109	74	31

Montana	11	11	16
Nebraska	31	11	16
Nevada	12	8	6
New Hampshire	25	8	20
New Jersey	64	54	37
New Mexico	25	12	9
New York	263	76	93
North Carolina	132	14	40
North Dakota	18	2	7
Ohio	123	46	60
Oklahoma	47	59	25
Oregon	44	18	31
Pennsylvania	224	72	172
Puerto Rico	45	25	0
Rhode Island	12	9	6
South Carolina	61	12	70
South Dakota	19	9	30
Tennessee	77	49	32
Texas	200	79	60
Utah	21	11	5
Vermont	16	3	23
Virginia	90	48	43
Washington	70	22	57
West Virginia	39	22	18
Wisconsin	81	4	57
Wyoming	11	5	11
TOTALS	3,510	1,605	1,643

SUMMARY

Fiscal Year	1986	1987	1988
Trainees			
Ch. 30	1	800	19,400
Ch. 31*	25,776	25,000	24,500
Ch. 32	63,221	71,200	74,000
Ch. 34	305,754	232,175	181,785
Ch. 35	52,939	47,243	42,265
Ch. 106	31,678	87,800	123,600
TOTAL	479,369	464,218	465,550
Institutions**			
IHL	3,894	3,706	3,510
NCD	2,239	1,895	1,605
OJT	3,296	2,325	1,643
TOTAL	9,429	7,926	6,758

* Programs for Chapter 31 trainees are approved by the VA, not the SAAs.

** Data reflects institutions and establishments which have or are projected to have a veteran (Chapter 34) or eligible person (Chapter 35) enrolled as of the end of October 1985, October 1986 and October 1987.

Veterans Administration

Memorandum

Date: JAN 23 1987

From: Chief Medical Director (10)

Subj: Vet Centers Pilot Project

To: Chief of Staff (00B)

1. On the basis of our preliminary assessment, I have identified 9 Vet Centers to serve as the first group of pilots to be physically relocated into medical centers. The identification of these medical facilities is based on an agreement between Regional Directors and Readjustment Counseling Service and represents a consensus on those sites with the greatest potential for successful implementation. The sites fully meet the intent of the criteria adopted by the Department (copy attached) for evaluating and selecting sites.

2. The 9 sites are:

Region	Vet Center	Medical Facility
1	Avon, MA [illegible] Rochester, NY [illegible]	Brockton, MA [illegible] Batavia, NY (Rochester VAOPC)
2	Wilmington, DE [illegible] Fayetteville, NC [illegible]	Wilmington, DE Fayetteville, NC [illegible]
4	Milwaukee, WI Oakpark, IL [illegible]	Milwaukee, WI Hines VA Hospital
5	Sioux Falls, SD [illegible]	Sioux Falls, SD
6	Northridge, CA [illegible]	Sepulveda, CA
7	Houston, TX [illegible]	Houston, TX

3. While it is initially believed that the transfer to the medical center can be accomplished with a minimum of unrest in the Vietnam Veteran community, the potential does exist for considerable media and veteran attention focused on the event(s).

John A. Gronvall

JOHN A. GRONVALL, M.D.

Attachment

Criteria: For transposition of Vet Centers to medical facilities

Criteria to be used for selection of vet centers for move to medical facility grounds (a) as pilot program affecting 7-14 sites during FY 1987, and (b) a larger number of sites, according to present law, during the period October 1, 1987 to September 30, 1989.

1. Acceptability:

   a. Assessment by Director, Readjustment Counseling Service, and Regional Director, after consultation with VAMC Director and Regional Manager for Readjustment Counseling that move is feasible.

   b. Recommendation for approval by Director, Readjustment Counseling Service, to the Chief Medical Director thru 10B and 10X.

2. Catchment Area Distributions of Vietnam Era Veterans Population by Census:

   County-based census data for Vietnam Era veteran population will be developed for catchment area of present vet center site and for medical facility location. The question to be answered: Is the medical facility adequately strategically located with respect to VEV population density, vis-a-vis the present vet center site? This factor will be assessed in relation to the total number of veterans seen by the vet center to date, since inception, which furnishes an estimate of the proportion of the target population already served, vs. the proportion yet to be served.

3. Distance (Mileage) Between Vet Center and Medical Facility:

   Distance between vet centers and medical facilities varies considerably, from a few miles to over a hundred miles. Vet Centers closer to medical facilities will rank higher on this criterion, depending however on analysis from criteria (1) and (2).

4. State Vietnam Era Veteran Outreach Centers:

   Some states have state VEV outreach centers, some of which provide services similar to VA vet centers. Availability of comparable services will be assessed, in relation to geographical distances, population concentrations, and anticipated duration of such state centers.

5. Vietnam Veterans Resource Centers:

With ten vet centers designated for re-configuration as VVRCs, these sites should be maintained as community-based facilities at least for the duration of the VVRC pilot project. Subsequent developments would then be contingent on outcome of pilot project.

6. Special Population Factors:

Certain vet centers principally serve an ethnic minority veteran population. Local assessement should determine availability and acceptability of medical facility site to such populations.

7. Transportation and Parking:

Assessment of public transportation, and, where applicable parking (i.e., high-density metropolitan areas) advantages and disadvantages of medical facility site in comparison to vet center location.

8. Availability, Cost and Suitability of Medical Facility Space:

To be assessed: (a) Presently available medical facility space; (b) One-time cost of space adjustments at medical facility, and (c) Operational suitability of medical facility space, in relation to other services.

9. Recurring Environmental Costs Comparison:

Total recurring environmental costs at present vet center location (rent, utilities, maintenance, parking) will be compared to such recurring costs at medical facility.

10. Contract Program Impact:

Size and workload projection, as affected by mileage and population density considerations, will be assessed for impact of move, in order to project presence or absence of pressure on contracts dollar utilization.

11. Actual Workload Trends at Present Vet Center:

Actual workload trends at present vet center will be assessed, and related to other factors including distance and veteran population densities. Examples of case-by-case analysis: (a) declining workload reflecting accomplishment of mission may favor avoidance of cost of move though decreasing size, or closing of present vet center, and (b) continuing high workload, notwithstanding relatively low veteran population, may favor a move. This analysis will be required for certain sites because of differing prevalence rates of readjustment difficulties in the target population.

BACKGROUND ON VET CENTERS
FOR MOVE TO MEDICAL FACILITIES

1. Avon, MA - Brockton VAMC: This vet center is located four miles from the Brockton VAMC. Therefore the move should not alter service delivery geographical considerations within the catchment area. As an older, longer-established vet center, the move to VAMC grounds would not be anticipated to alter the client workload of this currently-high producing team. The initial impression of the medical facility director and the readjustment counseling regional manager is favorable, and the medical facility has affirmed available space.

2. Rochester, NY - Rochester OPC: Acceptable to both vet center staff, readjustment counseling regional manager, and medical facility director, the suggested move of the Rochester vet center is targeted to station the bulk of their direct services at the Rochester VAOPC to enable continuation of the mission. The medical facility has been initially supportive with regard to space availability and transportation would not be affected.

3. Wilmington, DE: Both medical facility director and readjustment counseling regional manager are favorable about this move. Since vet center is located within five miles of the medical facility, client activity patterns within the catchment area are not anticipated to alter significantly. Workload trends at this vet center show a pattern of consistent productivity which is not anticipated to be negatively impacted. The medical facility has been affirmative about available space.

4. Fayetteville, NC: This move seems feasible due its initial acceptability to both medical facility director and regional manager. An older, established vet center, moving to the medical facility is not anticipated to affect the team's consistently productive client activity, and this would be a move of less than five miles.

5. Milwaukee, WI: A functional liaison between the vet center and the VAMC supports acceptability for the suggested move on both sides. This is a move of less than five miles. The highly varied veteran population within the Milwaukee area would have equal accessibility at either location.

The client productivity of an already adequate team would possibly be enhanced due to increased ease of referral within the medical center.

6. Oak Park, IL - Hines VAMC: This vet center is an older, established facility, which has developed a highly functional relationship within the medical facility. This would be a move of less than five miles which would not interrupt the center's mission from a geographical accessibility standpoint. Transportation and parking at the medical facility are quite adequate, and the hospital has been supportive with regard to space availability.

7. Sioux Falls, SD: Successful administrative and clinical liaison between this vet center and the medical facility have resulted in acceptability for this suggested move. This would be a move of about three miles, which would not be anticipated to interrupt the performance of the center's mission. The medical facility is supportive with regard to space availability.

8. Northridge, CA - Sepulveda VAMC: This suggested move has the support of the center team, medical facility director, and regional manager. This would be a move about six miles, which would therefore not alter the strategic location; accessibility to Asian-American and Hispanic veterans should be enhanced. Medical facility is supportive with regard to space, and transportation and parking would be improved.

9. Houston, TX: The Houston community currently has two vet centers. This move would involve the older center, whose functioning is sufficiently mature to preclude significant detriment to client services. Location change within the catchment area should not affect accessibility. Vet Center and medial facility staff are favorable; medical facility is supportive with regard to space.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
OF THE
U.S. HOUSE OF REPRESENTATIVES
February 3, 1987

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans and its Ladies' Auxiliary, I am pleased to appear here today to discuss the Administration's budget request for the Veterans Administration for Fiscal Year 1988.

As you know, Mr. Chairman, on behalf of the Veterans Administration, the President is requesting $27.6 billion in budget authority -- an increase of $548 million over Fiscal Year 1987 funding levels -- to administer the various programs and services for this nation's 78.5 million veterans, their family members and survivors of deceased veterans in Fiscal Year 1988.

MEDICAL CARE

The Fiscal Year 1988 budget request for the Department of Medicine and Surgery (DM&S) calls for overall budget authority in the VA's medical care account of $9.97 billion -- an increase of $414 million over the Fiscal Year 1987 level.

Mr. Chairman, in our view, notwithstanding the proposed funding increase, the VA's ability to provide quality and timely health care to America's veterans will continue to erode.

This is so in view of the fact that $393 million of the proposed increase in the medical care account has been requested specifically to absorb the cost of payroll increases, including the costs of the 1987 civilian pay raise and the 1988 Federal Employees' Retirement System (FERS).

According to the abbreviated budget document we have been provided, the Administration's budget request proposes, among other things:

* a $75 million rescission to eliminate funding that would otherwise be used during the last five months of Fiscal Year 1987 for the health care needs of so-called "higher income, nonservice-connected disabled veterans" (category C) who are thought to be financially able to provide for their own health care needs (a proposal which is in direct conflict with Congressional intent as embodied in Public Law 99-272);

* treating 13,548 less veterans on an inpatient basis in VA medical centers;

* treating 113,000 less veterans on an outpatient basis;

* a projected 1% productivity increase (in reality an arbitrary 1% budgetary reduction) estimated to save $58 million and reduce full time equivalent employees (FTEE) by 1,991 in Fiscal Year 1988;

* virtual elimination of the beneficiary travel program; and

* maintaining and operating 2,600 fewer hospital and nursing home care beds than mandated by current statute.

As you may have noted, Mr. Chairman, an additional 1,981 FTEE are being proposed to staff new activations in Fiscal Year 1988. However, the cumulative effect of the Agency's average medical care employment in Fiscal Year 1988 will be a reduction of more than 6,200 FTEE (inclusive of the proposed Fiscal Year 1987 rescission).

In our view, Mr. Chairman, this Fiscal Year 1988 VA medical care budget proposal will only serve to further impede the VA's ability to provide quality and timely health care to this nation's entitled veterans.

According to all estimates, the Administration's proposed DM&S budget for Fiscal Year 1988 falls at least $300 million short of the minimum funding level necessary simply to maintain veterans' health care services at current Fiscal Year 1987 levels.

Mr. Chairman, we encourage you and members of the Committee to carefully scrutinize the Fiscal Year 1988 funding levels proposed for the VA medical care account. We believe such scrutiny will lead you to propose a realistic and meaningful funding level that will, at the very least, enable the Agency to provide health care services to those veterans so entitled.

In this respect, Mr. Chairman, we would further urge you to carefully consider the recommendations and funding levels as contained in the Independent Health Care Budget for Veterans which has been provided to the Committee. This budget document represents the cumulative and cooperative efforts of several major veterans' service organizations (AMVETS, DAV, PVA and VFW) and represents, in our view, a realistic funding level that would allow the Agency to carry out its mandated mission of providing health care services to disabled veterans.

MEDICAL & PROSTHETIC RESEARCH

Mr. Chairman, the Administration's Fiscal Year 1988 medical and prosthetic research request is $198.7 million ($14 million below the Fiscal Year 1987 funded level).

The DAV has, and continues to be, fully supportive of the VA's combined research efforts. It is discouraging, however, to continue to witness the large disparity in the funding levels for medical research ($185.8 million) and that requested for prosthetic research ($17.6 million). The DAV supports the mission of Health Services Research and Development and we are encouraged by and support the funding requested. Likewise, we support the request for $2.4 million to fund an epidemiological study of women Vietnam veterans and the $4 million requested to continue to support the ongoing Agent Orange epidemiological study.

CONSTRUCTION

The VA's Fiscal Year 1988 construction request totals $525.7 million. Mr. Chairman, while we support full funding of the VA's request for construction purposes, we are nevertheless concerned over the VA's effort to meet the pressing demands on the health care system.

As you know, greater numbers of elderly veterans are seeking nursing home care from the VA, yet, in this construction budget proposal no funding is requested for nursing home care bed construction. Additionally, we are concerned that this construction budget request fails to recognize the replacement and modernization needs of the VA's many aging health care facilities.

We have noted and support the VA's proposal to convert 282 hospital to nursing home care beds. However, in so doing, we would urge the Administration to move swiftly in the conversion process and, when and where indicated, identify additional acute care beds that may realistically be converted to nursing home care. In doing so, we trust an appropriate balance will be maintained to meet the acute, intermediate and long-term health care needs of our rapidly aging veteran population.

DEPARTMENT OF VETERANS BENEFITS

The VA's Fiscal Year 1988 request for the Department of Veterans Benefits (DVB) totals $551 million, an increase of

$33.4 million over the Fiscal Year 1987 level. We are concerned, however, that average employment in DVB will decrease by some 296 FTEE.

Mr. Chairman, since 1980 some 4,900 employees have been slashed from DVB and, today, each regional office is barely staffed at minimum levels to adequately respond to the workload and demands for services placed upon it from veterans and their dependents.

We have grave concerns about the VA's ability to continue to provide needed services to beneficiaries and the proposal to reduce average employment will only serve to further curtail the services that the VA is charged to provide.

PROPOSED LEGISLATION

The Administration's Fiscal Year 1988 budget request proposes legislation that would provide for (1) an increase of 3.5% in the rates of disability compensation and Dependency and Indemnity Compensation (DIC), effective December 1, 1987; (2) index compensation benefits to the annual change in the Consumer Price Index; (3) change current law to provide for the VA plot allowance to be paid only in the case of those veterans who were either in receipt of VA compensation or pension benefits at the time of death or to wartime veterans who died without sufficient resources for burial; (4) increase the users fee on VA guaranteed home loans from 1% to 2.5%, effective June 1, 1987; and (5) amend current law to permit lender/borrower negotiated interest rates on VA guaranteed home loans.

Mr. Chairman, the DAV is pleased with the Administration's proposed cost of living adjustment in the rates of disability compensation and DIC benefits -- in recognition of the special consideration service-connected disabled veterans and their survivors should be given.

Accordingly, the DAV strongly supports the enactment of legislation that would provide disability compensation and DIC recipients with a cost of living adjustment in line with the rise in the Consumer Price Index, effective December 1, 1987.

As strongly as we support this rate increase, we adamantly oppose any effort to index compensation benefits to the annual change in the Consumer Price Index.

Mr. Chairman, in our view, the many and complex benefit programs administered by the VA deserve and, in fact, require continuous oversight scrutiny by the Congress and, specifically, the Veterans Affairs Committees.

Any attempt to index compensation benefits is, in our view, an attempt to diminish the oversight functions of the Congress. Such a result would not be in the best interest of the VA or, more importantly, the beneficiaries they are mandated to serve.

Additionally, we view the initiative to "standardize" the eligibility for the VA plot allowance as simply another example of an Administration effort to repeal an entitlement that has been bought and paid for by honorably discharged veterans. Accordingly, the DAV opposes this legislative proposal.

Mr. Chairman, the Administration is proposing several legislative changes to the current VA Home Loan Guaranty Program. Of particular concern to most veterans are the proposals that would increase the users fee from 1% to 2.5% and remove the Administrator's authority to set the interest rates for such home loans.

Quite frankly, these two legislative initiatives appear to be sufficient to effectively destroy the VA Home Loan Guaranty Program. Yet, the Administration is projecting that 340,000 loans will be generated next year by this program.

Mr. Chairman, why would that number of veterans willingly pay thousands of dollars in users fees for the privilege of using this program, even though not one nickel will be applied to reduce the principal of their mortgage? How much would they pay for this privilege over 25 to 30 years?

The DAV is adamantly opposed to any proposal to remove the Administrator's authority to set the interest rates on VA guaranteed home loans. Should this occur, interest rates would then be dictated by mortgage lenders at, we suspect, a level significantly higher than would be set by the Administrator. Without doubt, all veterans, including service-connected disabled veterans, would be adversely affected by such a procedure.

Coupling this exorbitant increase in the users fee with the removal of the interest rate ceiling nearly eliminates any benefit to veterans. We believe the Committee should carefully consider the adverse impact these proposals will have upon younger Vietnam veterans who are the primary beneficiaries of the program today.

Finally, Mr. Chairman, there is one proposal that is clearly missing from this budget request -- an estimated $40 million that is necessary for the VA to implement the changes to the Schedule for Rating Disabilities that were proposed by the VA last year.

As you will recall, Mr. Chairman, at Congressional direction, the VA conducted a study of veterans with hearing loss that was transmitted to the Congress during January, 1986. As a result of that study, numerous recommendations were made by program officials of the Department of Medicine and Surgery and the Department of Veterans Benefits.

Most notable of those recommendations was the need to revise the Rating Schedule to more realistically assign disability compensation evaluations for veterans suffering with profound hearing loss.

As we understand it, the recommendations were constructed in the form of proposed regulatory changes and transmitted to the Office of Management and Budget (OMB) during September, 1986, for their review and approval. Apparently, the proposed regulations languished at OMB until late December, 1986, when they were returned to the VA, unapproved.

Mr. Chairman, Section 355, Title 38, U.S. Code, authorizes the Administrator to adjust, from time to time, the Rating Schedule in accordance with experience.

Implicit in the nomination and confirmation of Administrator Turnage to his present position was the President's faith and confidence in his ability to act in the best interests of our nation's veterans.

It is abundantly clear, in our opinion, that the Administrator's decision to proceed with the promulgation of these proposed regulatory changes was in the best interest of veterans. Equally clear is the impediment of these beneficial changes by OMB strictly on a fiscal basis.

The VA clearly recognizes the fact that substantial changes must be made in the methodology in which hearing loss is evaluated and compensated for by the VA. We would therefore request, in the best interests of the large number of service-connected disabled veterans who would be affected by these regulatory changes, that the Committee give careful consideration to adding, to the compensation and pension appropriation, an appropriate funding level that would allow the VA to implement their desired regulatory changes.

Mr. Chairman, this concludes my testimony and I would again wish to thank you and the members of the Committee for allowing us this opportunity to present our views on the Administration's budget request for the Veterans Administration for Fiscal Year 1988.

STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE PRESIDENT'S PROPOSED FISCAL YEAR 1988 BUDGET FOR THE
VETERANS ADMINISTRATION

WASHINGTON, D. C. FEBRUARY 3, 1987

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the privilege of appearing before this distinguished committee to present the views of the Veterans of Foreign Wars of the United States with respect to the fiscal year 1988 budget for the Veterans Administration as proposed by the President.

According to the Veterans Administration, on September 30, 1986, there were approximately 27.7 million living veterans, 48.7 million family members of living veterans and 2 million survivors of deceased veterans. While obviously only a portion of these individuals will utilize the many VA benefits and entitlements available to them, they are all nevertheless potential beneficiaries and the VA must be prepared to adequately meet their needs.

Mr. Chairman, the President has proposed a FY 88 funding level for the Veterans Administration of $27.6 billion. This figure represents a $550 million increase over last year's total. However, the President is also proposing a $75 million rescission of FY 87 funds which the Congress has already agreed to spend on VA programs. Our first recommendation, Mr. Chairman, would be for the Congress, when presented with the rescission message, to reject it!

Most of the $75 million would come from the Department of Medicine and Surgery. In submitting the Administration's proposal, it was suggested the impact would be more greatly felt by category "C" patients as defined by Public Law 99-272. However, the VFW cannot visualize how these particular patients could be the only ones targeted. We predict that all categories will be affected and this certainly includes category "A" patients who now enjoy, thanks to the Congress, VA health care as an entitlement. We also question the Administration's decision to curtail health care to category "C" patients inasmuch as only this group contributes to reducing the deficit by actually paying the VA for health care through copayments. In addition, this particular group of patients is more likely to have medical insurance to help defray VA costs through third-party reimbursements.

As stated previously, the President's proposal recommends a rescission of VA FY 87 funds totaling $75 million. However, the Administration's proposed budget will only be implemented if the Congress accepts the Administration's recommendations. With respect to the proposed rescission, this money has been approved and targeted for programs by the Congress and its elimination only undermines the intent of the United States Congress.

Mr. Chairman, the President's budget proposal would scale back VA medical care by reducing VA employee levels by 3,810. Of course, this reduction in staff will only lead to a lesser number of patients being treated. This budget recommendation will effectively reduce admissions for inpatient, nursing home and domiciliary care by almost 12,000. There will also be a 113,000 reduction in outpatient visits.

These decreases cause the VFW much concern inasmuch as we predict an increase in demand for VA health care rather than a decrease.

The VFW is also concerned over the VA's $68 million funding level for the beneficiary travel account. We do not believe this amount will even come close to meeting the needs of our veterans. We have estimated this figure will barely provide for "emergency" transportation needs and, therefore, should be substantially increased.

With respect to major construction projects, the President is requesting $525.7 million, an increase of $36.9 million over FY 87. While the overall budget does show an increase, we are disappointed that the "replacement and modernization" activity shows a $102 million reduction from the FY 87 level. Approximately 53 percent of all VA beds are housed in buildings which are 30 or more years old. It can readily be seen that, unless the "replacement and modernization" activity is substantially enhanced, the VA's primary mission will be in jeopardy.

Another particular concern to the VFW is that no funds for new nursing homes have been provided because the Administration alleges that the VA can secure nursing home care through community and state programs. Here again, with the increasing demand from the private sector and the probability of long-term catastrophic care being approved under Medicare, as outlined by the Secretary of Health and Human Services, the VA may soon have to go begging for private nursing care space.

We are pleased the President recommends major construction projects to include Indianapolis, Indiana; Livermore, California; Waco, Texas and the Northern California cemetery. Also, the request for asbestos abatement projects is welcome.

The Veterans of Foreign Wars is also opposed to the excessing of property as requested by the President's real property initiative. Specifically, the Veterans of Foreign Wars does not approve of the request to excess some 90-acres of land in West Los Angeles and 32-acres at Sepulveda, California.

In summary, the construction budget is inadequate if the Veterans Administration is to maintain its current workload not to mention the impending increase in workload that appears on the horizon as stated previously. It is well-known that many buildings are 30 years old and some of these are of poured concrete construction wherein you cannot change your mind or exhibit any flexibility without a jackhammer. It is well-known that other buildings are in use which were built at the end of the Civil War, although, it is true that patients are not housed in these buildings. Over the years, some of the most antiquated type construction inherited from the military has been replaced--but not all. Here again, we have hopelessly outmoded physical plants which are able to produce high-quality care only through the dedication of VA employees and the expeditious use of equipment and new technologies often in space poorly designed for such gear.

Mr. Chairman, several legislative initiatives have been proposed by the President in his budget recommendations. One such proposal would "standardize" the cemetery plot allowance to that of the burial allowance. Of course, this innocent sounding term "standardize" means nothing more than another reduction in benefits. The VFW not only opposes reducing plot allowance eligibility solely to those in receipt of disability compensation or pension, but has adopted a resolution which calls for an increase in the allowance along with expanding the eligibility requirements. It should be kept in mind that the plot allowance is the single monetary benefit available to all veterans who served their country during wartime. It should also be noted that the plot allowance constitutes a significant portion of the operating budget for the various state veteran's cemeteries. Acknowledging the fact that state veteran's cemeteries are an integral component of the veteran's cemetery system, the VA has encouraged states to expand their facilities. Of course, the various states have relied heavily on the $150 burial plot allowance in their expansion endeavors. Should the President's proposal be enacted, the VA would be in the unenviable position of having to renege on a substantial incentive.

Mr. Chairman, the President's FY 88 budget is recommending two legislative proposals which would, in our opinion, severely undermine the very successful VA Home Loan Guaranty Program. One such proposal would increase the "user fee" for a VA guaranteed home loan from 1 percent to 2.5 percent. Inasmuch as we opposed the establishment of an "user fee" and its subsequent increase from one-half of one percent to a full one percent, we are now even more committed in our opposition to this proposed excessive and unwarranted increase. One of the attractive features of the Home Loan Guaranty Program is the provision of not requiring a down payment. Many of today's two-income families can manage a large monthly mortgage payment; however, they have not been able to save enough capital to meet the stiff down payment requirements of commercial lending institutions. As we have stated in the past, we perceive the "user fee" to be, in effect, a down payment without the benefit of equally reducing the amount to be financed. Of course, the veteran may opt to have this fee incorporated into the loan. This avenue, though, is hardly advantageous to the veteran. Assuming $60,000 to be the average VA guaranteed loan, a $1,500 user fee would be assessed. This original $1,500 amount amortized over 30 years at today's current market rate would require the veteran to actually pay around $4,500 or three times the required amount. In addition, there is the very real possibility of lenders requiring increased compensation for the higher risk of lending an amount greater than the value of the property. If a veteran opts to amortize the "user fee" and not render a down payment, the lender would then have to grant a loan for the current value of the property plus the user fee.

Mr. Chairman, the Administration is also proposing to repeal the Veterans Administration's authority to establish a home loan interest rate. We believe departing from this policy would be a serious mistake and detrimental to the veteran's best interest.

At present, the VA only establishes the maximum interest rate a veteran can pay on a guaranteed loan. Even though lenders may charge a lesser rate, cases such as this are rare or nonexistent. We believe, should veterans be forced to negotiate this rate, they will ultimately pay higher rates than they do now with an administered rate. One reason for this anticipated higher interest payment is that the lenders set the rate. Because most home buyers do not shop around for the best lending package, we do not foresee the "competitive factor" holding down the rate. In addition, VA guaranteed loans offer various benefits that are not always available on conventional loans. Assumability, no prepayment penalties and fixed rates are attractive terms that private lenders may consider as justification for assessing higher rates.

Not only would the veteran experience increased expenses with a negotiated rate, we believe the VA would witness increased claim costs should foreclosure proceedings occur. When a VA guaranteed loan goes to foreclosure, the claim is paid with interest based on the mortgage rate. Inasmuch as we expect higher interest rates, should this proposal be enacted, it can only be expected outlays will increase from the Loan Guaranty Revolving Fund. As one can deduce, it would also be very difficult to predict future revolving fund outlays with such a variance of interest rates throughout the nation.

Mr. Chairman, another area of concern is the Administration's recommendation to index compensation benefits to the annual change in the Consumer Price Index. We believe this action would, in all likelihood, reduce congressional review of the program. In the past, the Congress has been very compassionate and fair in addressing the needs of our nation's service-connected disabled and we foresee no benefit to veterans in substituting an automatic process for the personal attention of this committee and, for that matter, the entire Congress.

This concludes my statement. Attached, you will find resolutions adopted at our most recent National Convention which pertain to this hearing. I will be happy to respond to any questions you may have.

PVA

PARALYZED VETERANS
OF AMERICA

Forty Years of Service
1947-1987

STATEMENT
OF
R. JACK POWELL, EXECUTIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING THE
PRESIDENT'S PROPOSED FISCAL YEAR 1988
VETERANS ADMINISTRATION BUDGET
February 3, 1987

Mr. Chairman and Members of the Committee, I am R. Jack Powell, Executive Director of Paralyzed Veterans of America, and on behalf of the members of Paralyzed Veterans of America, a Congressionally chartered veterans' service organization, I thank you for affording me the invitation and the privileged opportunity to appear here today, during this all-important first session of the 100th Congress.

Let there be no doubt that PVA appreciates the Committee's efforts to conduct pertinent hearings and for the opportunity to express our views and concerns regarding this most important issue, the Administration's proposed Fiscal Year 1988 budget for the Veterans Administration. The entire PVA membership is comprised of men and women who have served in the military and are all veterans who have experienced catastrophic spinal cord injury or dysfunction. It is on behalf of these veterans that we present our views today.

Mr. Chairman, last year this Committee, as well as the House Committees on Budget and Appropriations, mindfully and with objectivity, rightfully rejected the Administration's FY'87 budget proposal for the VA. And, this year, "there they go again" (the Administration), as the FY'88 budget proposal reveals a continued disregard and concerted effort to cut the federal budget deficit in an arbitrary manner. For example, there is the proposal to seek an immediate rescission of $75 million from VA medical care appropriated in the VA's FY'87 budget. Additionally, the Administration attempts to portray the FY'88 proposal as one of providing increased funding for veterans, when under examination this premise is a facade, a cruel deception. It is riddled not only with the continuing attempt to reduce staffing and funding for VA programs, but also in effect, it undermines the responsible authority of Congress to authorize and provide appropriations. I will further discuss my viewpoint on this aspect throughout our testimony.

Mr. Chairman, in your press release of January 5, 1987, you "soundly rejected" the proposal for the FY'88 VA budget cuts and the $75 million

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Chartered by the Congress of the United States

rescission from VA medical care. Mr. Chairman, you further stated, "If Congress were to approve this proposal to rescind already appropriated '87 dollars -- which is highly unlikely -- the VA would have to reduce the number of inpatients treated by approximately 45,600 and cut 212,000 outpatient visits." PVA commends you for your stated position and we will go on record in support of the Chairman's comment.

It was reported in 1986 that already over 35,000 veterans a month were being turned away from the VA. The rescission is an effort to add fuel to the flame. Mr. Chairman, in no uncertain terms, veterans are, and well they should be, offended by the Administration's FY'88 VA budget proposal. PVA objects to the relentless attacks on veterans programs, and in particular to the budget proposal as submitted, for it is nothing less than a tenuous facade limited to less than a current services budget. This budget proposal is more than an effort to curtail federal spending and reduce the deficit, it is an overt effort to eliminate veterans' benefits and preclude veterans' access to needed services, particularly in the area of medical care. In reality this has been the case for too many years, recognizable as far back as 1981.

Mr. Chairman, on February 5, 1986 you stated, "It is now more crucial than ever that veterans rally, get into the thick of things, write, make phone calls, and resist attacks on their programs, especially those made through the budget process. The most important thing I can say to any veteran right now is join a service organization and get active; if you're already a member, stay active. It's the most effective tool you've got to help yourself and your fellow veteran, and it's essential to those of us on Capitol Hill who need to carry your input and your concerns through the halls of Congress." PVA agrees.

Mr. Chairman, I am pleased to say that in this vein, and near to your advice, several of the national veterans' service organizations have, indeed, joined forces with the purpose of providing the Congress and this Committee a unified statement and suggested independent budget, free of political forces, conceived with the purpose of establishing a realistic medical care budget for the VA. We in PVA believe you will find that the independent alternative budget is palatable, a document that you can accept and support, and a document that you can endorse and which can provide guidance to the entire Congress. Four major veterans' organizations, AMVETS, DAV, VFW and PVA, mutually worked together to provide this timely and necessary response to the budget process. I believe these organizations are tentatively slated for a hearing before the Subcommittee on Hospitals and Health Care of the House Committee on Veterans' Affairs and we welcome such an opportunity. This independent budget represents PVA's position on funding for veterans' health care for Fiscal Year 1988 and we appreciate the fact that you are providing a forum where we can share this position. The independent alternative budget to be presented to this Committee, will address at length the concerns regarding the budgets for VA health care, medical and prosthetics research programs and other various aspects of VA funding to meet the demands of veterans, both today and in the future.

Additionally, in January 1987, PVA in cooperation with the American Health Planning Association, released the completed study titled, "Veterans' Health Care: Actions and Interactions." This project was motivated by our deep concern for the health care provided to the men and women who serve, have and will serve in our nation's armed forces, both in times of war and peace and to whom we all owe our deepest gratitude. Briefings of the study have been presented in the Nation's Capital with four additional regional briefings being conducted across the nation. These documents are meant to support a realistic approach and understanding by all as to what the needs and necessary programs for veterans and their dependents actually are. These efforts can only reinforce the commitment of Congress to honor its obiligations to this nation's veterans.

As veterans, and as a part of the whole, we have witnessed that the Congress has kept its commitment to care for our nation's veterans since the days of Valley Forge through Vietnam. However, there are those who do not share in the responsibility. The Administration must be reminded that the costs attributed to war and the defense of freedom are high.

The proposed budget of $27.6 billion dollars purports to be an increase of $548 million above the current FY'87 budget. However, just as it was proposed last year, when examining the FY'88 VA budget request, we see it contains an excess of $1 billion in program cuts for benefits and services for veterans. This goal would be attained by virtue of OMB's effort to decrease the authority of Congress to finalize the appropriations for several programs. The most pronounced is the Administration's legislative proposals to attach cost of living increases for disability compensation and Dependency and Indemnity Compensation to the Consumer Price Index, which is unacceptable to PVA.

Included in the President's Fiscal Year 1988 Budget are a package of specific legislative proposals addressing changes to certain veterans' programs. I will address each proposal individually.

1) The Administration's Budget Proposal includes a provision to rescind $75 million dollars already appropriated for FY 1987 by eliminating funding for the care of higher income, nonservice-connected veterans. Further, this budget proposes reductions of approximately 4,000 FTEE's and approximately $220 million in associated funding for fiscal year 1988.

PVA soundly rejects these budget reductions and we will strongly oppose any proposal designed to eliminate VA hospital and nursing home care to any category of eligible veterans. PVA believes this proposal is an attempt to usurp Congressional authority and blatantly ignores the Congressional intent of P.L. 99-272, the "Consolidated Omnibus Budget Reconciliation Act of 1985." The law established three categories of veterans' health care eligibility, through a provision known as the "means test." This law specifically provides that veterans who have nonservice-connected disabilities and whose incomes exceed certain specified amounts, may receive hospital or nursing home care on a space- available basis if they agree to make a modest co-payment.

Mr. Chairman, as you are so acutely aware, prior to P.L. 99-272, all eligible veterans received VA care as a result of service to our nation and were not required to pay for it. PVA believes that the "means test" was a desperate attempt to help control burgeoning federal budget deficits, while at the same time maintaining the nation's commitment to the men and women who served. This is the intention of today's U.S. Congress. The President's proposal simply is not fair and is obviously inconsistent with the intent of the legislation promulgated in the 99th Congress.

The President's proposal is designed to reduce the size of the VA's health care system through the elimination of funding for category C veterans, PVA will not support this. In addition, PVA believes that the aforementioned budget reductions and particularly FTEE reductions, if approved, would impact negatively on the remaining categories of eligible veterans. At a December 10, 1986, meeting between the various veterans' service organizations and the Chief Medical Director, PVA was informed that with regard to FY 1987 FTEE levels, Department of Medicine & Surgery was already looking at a shortfall of approximately 200 FTEE per region with urban areas facing the most severe shortages. Mr. Chairman, health care personnel shortages certainly affect the quality of care received by all eligible veterans.

Even at current staffing levels, the VA is going to be very hard pressed to address the specific and emerging special program areas of: Services to aging veterans; Vietnam veterans; veterans exposed to Agent Orange and Ionizing Radiation; former Prisoners of War; and of particular concern to us, certain VAMC's may not be able to provide the highly specialized care and rehabilitative services to those veterans with spinal cord injury or disease. The President's proposal would serve to add more burden to an already critical situation in the VA. Hence, all veterans receiving VA care are negatively affected. It is grossly apparent that this particular budget proposal was drafted with only random budget slashing as its goal and without regard to Congressional intent and ignorant of the nation's moral obligation to its veterans.

Mr. Chairman, the Senate Committee on Veterans' Affairs has already formally expressed its outrage with this provision through the introduction and unanimous co-sponsorship by all its Members of S. Con. Res. 7. It is the hope of PVA that each and every Member of this distinguished Committee will also rise and formally oppose this unfair proposal.

2) The Administration's budget provides for a 3.5% increase in service-connected disability compensation benefits and proposes that the annual cost-of-living adjustment be indexed to the annual change in the consumer price index and therefore adjusted automatically. The COLA now requires annual Congressional action, a process which PVA believes ensures

Congressional control and results in greater flexibility and fairness in a fluctuating economic climate. Mr. Chairman, and Members of the Committee, I respectfully call to your attention yet another OMB attempt to by-pass Congressional authority.

3) The Administration requested that all benefits under the New GI Bill be transferred for payment by the Department of Defense, thereby making it a permanent retention and recruitment program. Mr. Chairman and Committee Members, we all know that, historically, the GI Bill was meant as a readjustment benefit, rightfully paid and administered by the VA. We see no reason to change this. PVA also opposes the transfer of funding responsibility because we believe that separating the administration of a program from its funding source is inefficient management. Furthermore, this proposal will not result in cost-savings since it only represents a funding shift. To quote a favorite phrase of yours, Mr. Chairman "if it ain't broke, don't fix it." The Administration may have already begun to see the light on this one as witnessed in the most recent State of the Union address.

4) Another provision in the Administration's budget, if enacted, will increase the VA Home Loan Guaranty Program "user's fee" from one percent to 2.5%, effective June 1, 1987. It is estimated that the proposal would amount to an average increase of $900 in the fee paid by a typical veteran home buyer. PVA has consistently opposed similar proposals in the past and remains strongly opposed now. Congress, too, has rejected these proposals in the past. We believe that an increase in the user's fee would have a serious detrimental effect on the ability of veterans to obtain guaranteed loans, and thereby discourage veteran's home ownership. Any attempt to dismantle the VA's Home Loan Guaranty Program is a serious disservice to this nation's veterans. Without a doubt, the VA Home Loan Program, having assisted millions of veterans in obtaining suitable, affordable housing, has been one of the most successful government programs in this nation's history. This program has been a sound investment in America, providing stability and expanding the tax base of nearly every community in our country.

5) The Administration proposes a $22 million reduction in burial benefits by standardizing the eligibility criterion of the plot allowance with the burial allowance. In effect, burial benefits would only be provided to service-connected deaths and veterans receiving either compensation or pension payments at the time of death. Once again, the Administration is attempting to deny a category of eligible veterans a promised benefit. By limiting the plot allowance to the above veterans, the Administration assumes responsibility to only those service-connected veterans or nonservice-connected veterans in receipt of pension who are therefore already designated as economic hardships. Even this premise is faulty, because many nonservice-connected veterans over the age of 65, who are eligible for VA pension, opt instead for participation in other government programs such as Social Security. Veterans receiving Social Security payments may be equally as in need of that $150 plot allowance as the nonservice-connected pension recipient. The Administration's efforts are misguided if they are attempting to identify those veterans "in need" of the benefit.

6) The 1988 budget contains $6 million and nine FTEE to reactivate the Health Professional Scholarship Program to support 211-one year awards and 84-two year awards to nursing and physical therapy students. PVA applauds the Administration's efforts to ease the critical personnel shortages in these areas by providing this recruitment technique. It is imperative that the VA have the ability and funding necessary to recruit and retain high quality health care professionals. It is however incongruent that the Administration while reinstituting this important program would at the same time propose reducing actual FTEE levels in the Department of Medicine & Surgery.

7) PVA wishes to express its deep concern over the Administration's proposal to cut 296 FTEE from the Department of Veterans Benefits. Included within the aggregate of the proposed personnel increases and decreases for the Department are a 210 FTEE reduction from compensation, pension and education adjudication staff, 45 FTEE in support services, 16 FTEE from Vocational Rehabilitation, and 95 FTEE from Veterans Services.

The budget justifies these cuts citing declining workload caused by decreased participation in the Vietnam Era G.I. Bill and on-going "efficiencies" in the claims adjudication process. On analysis, we find these arguments shortsighted. Any stated decrease in workload within the Department must be measured not only by the number of veterans' claims pending, but also by the complexity of those cases being adjudicated on a day-to-day basis by an already overworked and overtaxed DVB staff.

Staffing levels for the Department of Veterans Benefits have been under severe attack for the past several years. Most VA Regional offices are struggling right now just to meet basic timeliness and quality-of-service standards. Any further erosion at this time, we feel, could seriously degrade the quality of ongoing adjudication services provided by the VA. Adjudication, veterans services and support staff are on the front line of benefit delivery within the VA. We will strongly support any effort made by this Committee and the Congress to restore funding for these key personnel.

CONCLUSION

Last year the President proclaimed November 11, 1986, as "Veterans Day." The following excerpts to quote the President, he said, "Veterans Day gives all Americans a special opportunity to pay tribute to all those men and women who, throughout our history, have left their homes and loved ones to serve their country...From Valley Forge to Vietnam, through war and peace, valiant patriotic Americans have answered the call, serving with honor and fidelity...On this special day...they are indeed worthy of the solemn tribute of a grateful nation..." PVA would comment, that indeed veterans have served with honor and fidelity, only to look the enemy in the eye, the veterans have never turned their backs on this country and, while the veteran has served valiantly from the days of Valley Forge through Vietnam and since, we do not understand but, if we must, we will, year after year, continue to fight the battle of the Veterans Administration's insufficient budget request.

Finally, Mr. Chairman I must address what PVA perceives as a not so subtle attack on the very premise of veterans' benefits in the Administration budget proposal. Veterans' benefits and programs are not addressed as a unique, national obligation but are encompassed in the broader areas of revenue transfer and federal health care. This demonstrates a blatant disregard of the service rendered by this nation's veterans and signals an overt attempt to enmesh the Veterans Administration and its programs into the larger systems of welfare and support services provided by the federal government. PVA rejects such a shift of government philosophy and requests that you, this Committee and all of Congress, continue to recognize and support veterans' benefits and programs as earned by the men and women who have served the nation and that these benefits have been prepaid by these veterans.

Mr. Chairman, per your invitation, PVA is scheduled to present on February 25, 1987, our Annual Testimony, in a Joint Hearing by the House and Senate Committees on Veterans' Affairs. At that time our testimony will include various other concerns and recommendations. These recommendations are too lengthy for presentation here today.

We appreciate the fact that this Committee has and will provide careful examination of the proposed funding for the VA and the needed scrutiny of the VA's programs to provide the necessary appropriations which you have done in the past. Further, we trust and continue to believe that your commitment to the veterans mirrors the intent of Congress.

Mr. Chairman, that concludes my statement. Thank you and the Members of the Committee for your extremely deliberate and thoughtful considerations of this issue. I will attempt to answer any questions that I can.

VETERANS' HEALTH CARE: ACTIONS AND INTERACTIONS

Executive Summary

January 1987

PVA
PARALYZED VETERANS
OF AMERICA

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

January 1987

Dear Colleague:

Paralyzed Veterans of America is pleased to release its study, "Veterans' Health Care: Actions and Interactions." This project was motivated by our deep concern for the health care provided to the men and women who served in our nation's armed forces both in times of war and of peace. To them we all owe our deepest gratitude.

For more than half a century, the Veterans Administration has provided our veterans with health care of exemplary quality. The task becomes much more difficult, however, as federal resources become increasingly constrained. To its credit, the agency has cared for greatly expanding numbers of veterans and initiated new and innovative programs in the past decade in spite of a no-growth budget in terms of constant dollars.

As expenditures for domestic programs are reduced in an effort to bring down the deficit, the issue is whether the VA can continue to provide high quality medical care to veterans at the same time the numbers of aging veterans are reaching staggering proportions. If the agency cannot, can veterans, many of whom are poor and uninsured, obtain health care in the non-VA sector?

This study deals with the health care alternatives available to veterans if the size of the VA's health care delivery system were reduced due to budget constraints, or if it were not expanded to accommodate increased need and entitlement. The unifying theme which emerged is interactions, the symbiotic relationship between the veterans' health care system and the nation's health care delivery and financing programs.

This study is of significance not only to veterans and their traditional supporters, but to all who have an interest in the provision of quality health care to America's citizenry.

Sincerely,

Richard D. Hoover

Richard D. Hoover
National President

Jack Powell

R. Jack Powell
Executive Director

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300

Prologue

The driving force behind public policy in the mid-1980s is a concern for dollars, not people's needs. This is eroding federal funding levels for health care and social support programs.

Budget cuts have directly affected Medicare, Medicaid, community health programs, health professions education, medical research, and veterans' health care, among others. Each of these program areas has directly and indirectly experienced substantial budget reductions, or is targeted for future cuts.

There is no evidence the people's need for such programs has decreased. Indeed, with the aging of the population and the number of persons who are uninsured, underinsured, and uninsurable increasing, the need is growing.

In view of this continued need, the result of declining budgets must be either a failure to meet the need, or a shift of the costs of meeting it from federal resources to some other funding source.

The effects of budget cuts on individual programs have been documented. The cumulative effects on meeting individuals' needs have not.

Background

In the mid-1980s, the American health care system has lost much of the structural and financial stability it has had through the last five decades. The pace of change is rapid. New approaches to financing and organizing health care are appearing almost daily. The health care system is widely described as becoming "industrialized."

This transition toward a more "business-like" health care market is characterized by:

- Extensive public and private efforts to control costs of medical care through "prudent purchasing" and "managed care";
- Limits in government budget allocations to health programs, forcing changes in their management, scope, and benefits; and
- Increased emphasis on out-of-hospital health care and a shifting towards individual financing without "risk pooling."

The change is creating new problems for some groups within the population and for the nation:

- Access to care is declining for those without financial means, despite an increasing excess in institutional acute care capacity;
- Hospitals with a limited financial base—often public and rural hospitals—are experiencing serious economic conditions which affect their viability; and
- Growth in new approaches to providing both institutional and non-institutional care for an aging population is lagging.

As this transition grips the health system at large, it also affects the Veterans Administration health care system. The VA is rarely mentioned in discussions and studies of changes occurring in health care today. Yet it cannot be considered as separate from the rest of the health care structure. There are too many interactions between VA and non-VA health care delivery and financing activities.

Although there was almost continuous expansion in veterans' benefits and eligibility for VA medical services for nearly half a century, the last decade has seen VA's medical care budget remain essentially level in real dollar terms. In the mid-1980s, veterans are observing cutbacks in funding allocations for the VA medical care system.

Policies guiding these changes have emerged from many different sources. They reflect a wide range in conceptions of the VA's obligation to America's veterans and the most effective means of meeting that obligation. Policy options put forth in debates concerning constraining the health care for veterans provided by the VA's health care system include three types:

- Policies which would reduce utilization by making VA medical services either less attractive or less accessible to veterans;
- Policies which would reduce availability by shrinking the size of the VA system or changing its makeup substantially, forcing current and potential users to seek another source of medical care; and
- Policies which would directly shift financial responsibility for costs of veteran health care from the VA budget to other sources.

The Paralyzed Veterans of America, an organization of veterans with spinal cord injuries or disease, has a broad interest in the care rendered all veterans under commitments enacted by Congress over the years. PVA is concerned with effects of such policies at the community level on individual veterans. It is also concerned with policy changes in other benefit programs and their interactive effects on veterans' health care and the nation's health care system.

> ***"The VA . . . cannot be considered as separate from the rest of the health care structure."***

In 1985, PVA sought the assistance of the American Health Planning Association, the national organization of professional health planners, in assessing effects of changing health care and social policies on a changing veteran population. AHPA was asked to examine the consequences of a variety of policies on veterans' access to care in selected VA medical districts, and to focus on interactions between VA care and other sources of care at the district level.

The study was conducted in four of the VA's twenty-seven medical districts. The district level was selected to coincide with data sets developed by the VA's Medical District

Initiated Program Planning (MEDIPP) process and non-VA data from plans prepared by health systems agencies and state health planning agencies. Since there is no national-level planning for the non-federal health care system, and very little among federal programs, this "grass-roots" approach was believed essential to an examination of interactions.

Among the concerns of the study were:

- The extent to which policy and budgetary changes directed at the VA health care system affect the non-VA system, and the extent to which changes in the organization and financing of the non-VA system has effects on veterans' health care;
- The effects on access to VA services for current veteran users which might result from a "downsizing" of the VA system, whether in response to severe budget cuts, changing incentives in the system, or failure to maintain or expand capacity adequately in the face of increased demand;
- The potential for veterans who might lose access to VA health care services as a result of implementation of selected budgetary or policy changes to find equivalent care in their communities;
- The extent to which the growing needs of older and frailer veterans could be met effectively by the VA under its current plans for development of geriatric and long term care services;
- The extent to which downsizing (e.g., reductions in services, closures, or conversions) made to achieve Administration budgetary goals for the VA would shift substantial costs to other federal budgets, or from the federal to state and local health care budgets;
- The amount of cost shifting or cost transferring to the VA from non-VA providers and payers which might occur as a result of changing eligibility levels; and
- The degree to which downsizing and/or mission changes of VA medical centers would have adverse effects on the VA non-patient care missions—health professions education, medical research, and backup to the Department of Defense in times of national emergency.

This Executive Summary provides highlights of the findings of the study. Additional publications include the Final Report and the Study of Four Veterans Administration Medical Districts

General Observations

IN THIS STUDY, THE UNIFYING THEME IS INTERACTION

The effects of changing budgets and eligibility requirements on access to health care for individual veterans are not determined solely by the policies of the VA. Rather, they are the result of interactions among decisions, usually uncoordinated, affecting diverse programs under federal, state, and local authority. Uncoordinated policies lead to unanticipated results, and often produce negative consequences for the veteran, the VA medical system, the U.S. health care system, and the nation.

Interaction is the glue which holds individual systems together and which relate such systems to one another. It is impossible to consider any one mission of the VA's medical care component in isolation from the others. It is equally impossible to consider the VA and its medical services without looking at the larger health care system in the country.

Considering such things in isolation, of course, simplifies analysis. It allows generalizations concerning the effect, or lack of effect, of changes in one component of a system or one system within a larger system. Analysis in isolation, however, produces results which may not hold up in the dynamic world of systems' interaction.

"Analysis in isolation . . . produces results which may not hold up in the dynamic world of systems' interaction."

The absence of a systems approach to budget development, review, and enactment at the federal level leads to decisions in regard to one agency or program without consideration of the decisions' effects on others. This problem is pervasive in consideration of health issues, where various elements of the total responsibility for federal health policy lie in different budgetary units and fall under the jurisdiction of different Congressional committees.

This problem becomes particularly critical in times of financial stringency, when efforts to contain expenditures in one program lead to unanticipated consequences in another, and when "acceptable" cuts in two different programs have a synergistic effect, causing problems greater than the sum of the individual program cuts. Examples of these interactions abound in health care and in the VA system. The Congressional budget process, which focuses on the "bottom line," is not sufficiently sensitive to deal with the systematic interactions among health programs.

IN THIS STUDY, THE FOCUS IS ON INDIVIDUAL VETERANS' NEEDS

Many studies directed at the future of veterans' health care have been conducted by many different groups. Such studies have almost exclusively focused on costs and the aggregate of all veterans rather than issues of need and the individual veteran.

In recent years, a large number of studies and commission reports examined the VA medical care system and recommended changes—usually cuts—in its operations. These studies have suggested a number of "solutions" focused on reducing costs experienced by VA in meeting the needs of its beneficiaries. They usually have not concerned themselves with need—the requirement for medical care for individuals based on health status, socioeconomic status, or other personal characteristics. They have focused on system resource factors such as cost—cost savings, cost avoidance, and cost containment.

In an effort to lower costs, policies were suggested which would create eligibility or financial barriers to access, would reduce or limit the amount or mix of services, or would shift financial responsibility for costs of veterans' health care from the VA budget to other sources, such as private insurers, other governmental programs, or the veteran's personal resources.

Given the scanty data available concerning veteran income —a major factor in determining alternatives for current users under changing eligibility conditions—and veteran insurance status—key to determining both access to alternatives and potential collections for services rendered by VA—the "savings" credited to such policies are, at best, speculative.

An example is the high proportion of veteran users of VA health care identified in the course of this study as underinsured, uninsured, uninsurable, or medically-indigent. In most of the study districts, the VA clearly serves a major safety-net function in providing care to those with few, if any, realistic alternative sources of care.

Under Public Law 99-272, the Veterans' Health Care Amendments of 1986, these veterans have expanded eligibility for inpatient hospital services. Their numbers become important in planning future need for VA hospital capacity. Implementation of that legislation should lead to an improvement in VA's data concerning socioeconomic status of its beneficiaries as a result of application of this "new" means test.

IN THIS STUDY, PROBLEMS IN ACCESS ARE APPARENT

Veterans who are eligible for VA care, who desire VA care, and who have a potential source of such care nearby have not enjoyed equal access in the past, and may not in the future.

Under the priority system governing access to VA health care at the time of the district studies, there was unevenness of access across the study districts. This resulted from the fact that nonservice-connected veterans were only afforded access on a space-available basis. In districts with high use by service-connected veterans, like Medical District 12, access opportunities for the nonservice connected were limited. In districts where use by service-connected veterans was low, like Medical District 17, lower priority veterans had an excellent opportunity to obtain needed care.

With expansion under Public Law 99-272 of the pool of veterans for whom the VA must provide certain types of care, the inequity which has existed will be lessened or eliminated for hospital inpatient care. There is, however, potential for other problems in equity of access under the new means test. First among these is the possibility the mandatory access for entitled veterans will overtax the system's capacity and financial resources. Under those circumstances, some eligible veterans might be unable to secure inpatient acute care.

"There is . . . potential for other problems in equity of access under the new means test."

It is also important to reiterate this entitlement under Category A as prescribed by Public Law 99-272 extends only to inpatient hospital care and does not guarantee nursing home and outpatient care. With an aging population, access to nursing home care will become an increasingly important issue for veterans. With differing supplies of beds in different areas, access to such will vary considerably.

Specific Findings

EFFECTS OF DOWNSIZING OF SYSTEM

Downsizing of VA acute hospital capacity in any of the study districts would have significant impact on access to care for large numbers of current users of VA services, as well as for the expanded user group identified under P.L. 99-272. If the resources "saved" in such downsizing were not retained in the district and allocated to the remaining institutions and to development of VA alternative services, many of today's users of VA services would be forced out of the VA system.

Expanded eligibility achieved through the means test under Public Law 99-272 argues against reducing the size and scope of services in the VA system. Certainly the need for services, already heightened by the aging of the veteran population, will further expand as a result.

One response to a substantial cut in resources allocated to the VA would be to undertake "vertical" cuts, which eliminate entire facilities or classes of services. In this study, a vertical cut scenario was applied using 1984 MEDIPP data. Each VAMC in each of the four districts was "closed" in turn, and its patient load "redistributed" to the remaining VAMCs within the district. This exercise demonstrated the vertical approach would create problems in terms of excessive loads, relocation of services, and time/distance access to services for veterans.

At the same time data which supported the 1984 MEDIPP plans were assembled, the VA initiated a new resource allocation strategy based on "weighted workload units," measures which are similar to the New Jersey diagnosis-related groups (DRGs). The response within the VA, like that in the private sector, has led to reduced occupancy rates and shorter lengths of stay. These in turn had a marked effect on the closure scenario model, lessening the effects of a closure on remaining institutions in a district. However, the decrease in lengths of stay and occupancy rates in the 1984-86 period have been accompanied by a greater turnover rate through increases in numbers of patients treated and the intensity of treatment required.

> ***". . . the decrease in lengths of stay and occupancy rates have been accompanied by a greater turnover rate through increases in numbers of patients treated and the intensity of treatment required."***

This study suggests several critical factors which should be taken into account concerning veterans' health care, with or without applying a scenario of VA system downsizing:

- The potential increase in demand for acute care inpatient services which will accompany the rapid aging of the veteran population;
- The potential increase in demand for hospital inpatient care which may result from changing eligibility standards under Public Law 99-272;
- The need to develop very soon sufficient capacity in long term care to meet the needs of a rapidly escalating population of eligible older veterans;
- The need to develop adequate numbers of VA non-institutional programs to meet the needs of those currently cared for in hospitals, but more appropriately managed in non-hospital settings; and
- The regional variations in current acute hospital capacity and in capability to accommodate to changing needs of an aging population.

The changing occupancy and lengths of stay situation reflects a changing approach to meeting the need which involves less use of acute inpatient health services. In the private sector, similar changes have led to earlier discharges of patients than before, contributing to a growing demand for home health care and nursing home services. Similar effects can be expected in the VA system, intensified by the more rapid aging of the veteran population.

Given the age, socioeconomic status, and multiple illnesses common among veteran users of VA services, comparisons of the VA with the private sector appear to be of limited validity without more careful and rigorous analysis.

AVAILABLE AND INACCESSABLE NON-VA ACUTE CARE

The results of this study suggest adequate acute care capacity is available in the private sector to absorb many VA patients. However, hospitals do not seek to provide free care in a competitive environment and most current and potential users of VA medical care lack the financial means to access such services.

Capacity estimates were prepared taking into consideration major trends in the industry, such as expansion of HMOs, effects of DRGs, and aging of the general population. It was found that each of the study districts, with the the exception of the Southwest (MD 24), has, and will continue to have, non-VA hospital capacity in excess of need. The excess capacity will actually worsen under influence of changes in organization and financing taking place in the non-VA sector unless beds are taken out of the system through financial failure, regulatory action, or conversion to a different variety or level of care.

Earlier policy studies have suggested the excess acute care capacity in the non-federal sector represents a prime resource for meeting all or part of veterans' acute care needs. However, if VA budgets were restricted sufficiently as to require closures, it is unlikely federal financial support through the VA would be made available to meet the costs of care to displaced veterans in other settings. Yet they would have to seek care in those settings, using personal resources or other sources of funding.

The health care system in the U.S. is becoming more competitive as government, third-party payers, and corporate purchasers all seek to limit their costs. Access to health services is becoming increasingly dependent on being able to pay out of pocket and through private health insurance programs. Thus, the ability to receive adequate care in the private sector is dependent on personal financial and insurance status.

Free care given by private hospitals to individuals unable to pay is increasingly a casualty of the changing reimbursement system. Hospitals are under pressure to contain costs in order to meet limits on payment imposed by Medicare's prospective payment system and prudent purchasers and, consequently, are less able to provide free care through subsidization from other payers.

Despite data limitations in this regard, estimates prepared during the study suggest significant numbers of users of VA medical care are low-income individuals uninsured for health care. Unless the VA were willing to pay for the care rendered such individuals outside the system, private health care does not appear to be a realistic alternative for these veterans. Thus, veteran users having few resources who can no longer gain access to VA care may go without needed care, since veterans would be added to the uncompensated care clientele for the private sector.

"... veteran users who can no longer gain access would be added to the uncompensated care clientele for the private sector."

DEMANDS OF AGING AND CHRONIC CARE POPULATIONS

The most serious problem facing the VA in each of the districts studied is that of inadequate institutional and non-institutional capacity for an aging veteran population. While each district is experiencing rapid growth in the numbers of older veterans, the districts with the greatest growth in numbers of such veterans are already "behind the curve" in terms of resources.

As the number of veterans reaching the older age group increases, the number of veterans requiring long term institutional and non-institutional care also increases. In the study districts, the percent of veterans 65 and over projected for 1995 ranges from a low of 27 percent in MD 24 to a high of 44 percent in MD 12.

At the same time, the MD 12 MEDIPP plan suggests the district lags behind other study districts in terms of both acute hospital beds per 1,000 veterans and nursing home beds per 1,000 veterans over 65 years of age. This unevenness in distribution of resources will get worse with the passage of time unless substantial infusions of new resources or redistribution of existing resources takes place.

"... unevenness in distribution of resources will get worse with the passage of time unless substantial infusions of new resources or redistribution of existing resources takes place."

The VA has not been provided the resources to meet the needs of all eligible veterans who require care and seek to receive it from the VA. This can be expected to continue as demands mount as a result of the needs of an aging veteran population.

The VA has recognized the need to secure non-VA resources in meeting its needs for chronic care in the institutional setting through contracts with community nursing homes and assistance to state-owned and operated nursing homes. There have also been effective efforts, on a demonstration basis, to engage community resources for provision of non-institutional chronic care to veterans. Expansion of these activities to become a routine part of the VA approach to such care will be essential if VA is to meet its commitment to its aging population. This strategy would be advantageous in assisting communities in planning and developing non-institutional chronic care programs which are also needed to care for non-veterans.

One effect of the application of DRGs in the private sector has been to raise the importance of effective discharge planning—to be able to place patients who require additional skilled care in appropriate non-hospital settings. With the introduction of a similar approach to resource allocation in the VA, discharge planning and placements will assume increasing importance there as well. In order for such planning to be effective, however, there must be an array of appropriate alternatives to hospital care available in suitable amounts.

NURSING HOME CAPACITY IMPERATIVES

A major issue which emerged from the study is the feasibility of the current (FY 87) formula for allocating veterans requiring long term care among VA-owned, community, and state-owned nursing home beds. Expansion of capacity in all three categories of beds is lagging behind the need estimates in all four districts.

In the VA planning methodology which developed figures on need for long term care beds, there is an assumption that the VA "market share" will be 12-16 percent of all veterans requiring nursing home care. The VA planning process does not expect to meet the needs of all these veterans within VA-owned facilities nonetheless, but rather through a combination of VA operated beds, state-owned facilities, and community nursing home beds under contract.

At the time the MEDIPP plans and the data used in the study were developed, MEDIPP policy guidance held that 40 percent of the market share should be met in VA-owned beds, 40 percent in community beds, and 20 percent in state beds.

> ***"If VA is to achieve its goal of meeting 40 percent of the need in community nursing home beds, it will have to compete directly with other payers."***

The study results show that it is an unrealistic policy in terms of the expectation that 40 percent of the need could be met in community beds. Nursing home beds, unlike hospital beds, are not in excess in the non-VA sector. The study showed need for additional nursing home beds to meet even non-VA requirements in every study district. If VA is to achieve its goal of meeting 40 percent of the need in such beds, it will have to compete directly with other payers, including individuals, families, state Medicaid programs, and Medicare, for the beds.

After the study was underway, the VA altered its policy regarding the distribution of VA sponsored patients. The formula was changed to 30 percent VA-owned, 40 percent community, and 30 percent state-owned beds. This allowed a "savings" in the VA budget since the agency pays only a part of the cost of constructing and operating state homes and maintaining patients in these homes. It raises further questions concerning VA's nursing home care planning policy, however, since there is no evidence that suggests states will accept this cost shift from the federal budget during a time when their own budgets are tight. Also, the states are under no obligation to meet the 10 percent increase assigned to them for expansion of nursing homes as determined by the VA.

> ***". . . there is no evidence that suggests states will accept this cost shift from the federal budget during a time when their own budgets are tight."***

COST AND RESPONSIBILITY SHIFTING

Downsizing the VA medical system can be demonstrated to save dollars in the federal budget for the Veterans Administration, but the age and economic status of users of VA services indicate much of the cost "saved" will be shifted to other federal, state, and local government payers.

The financial profile of users of VA services developed for each study district confirmed other studies which indicated users are older, poorer, sicker, more disabled, and less well insured than other veterans. They also have fewer community and family support mechanisms available to them. To the extent such patients are displaced from VA services, their options for receiving needed health care are limited.

These data highlight the system's very significant "social" role. The VA cares for a large number of individuals who would otherwise be beneficiaries of other public programs or who would receive no care at all. The options—Medicare, Medicaid, and state and local indigent care programs—are governmental programs. Self-pay, particularly for hospital services, is not a realistic option.

> ***"Self-pay, particularly for hospital services, is not a realistic option."***

Medicare represents an option for veterans who meet the eligibility requirements. Surveys suggest 90 percent of veterans 65 and over are Medicare-eligible. Such veterans, if unable to gain access to VA care, would have access to private acute hospital care through their Medicare coverage, although coverage of long term care is extremely limited.

Poorer, older veterans—those with low incomes and without medigap coverage for Medicare—will have problems meeting the increasingly high co-payment requirements of the Medicare program. For older veterans, who qualify for VA care and obtain access, the wider range of services and essentially unlimited benefits in the VA might make VA care the preferred alternative.

Medicaid is difficult to characterize sufficiently to permit conclusions as to the role it might play in replacing VA as a source of financing for displaced users. Although there are required minimum benefits, there is a wide range of state-specific requirements and varying levels of coverage from state to state. Further, eligibility requirements and scope of coverage are continuously in flux as a result of declining federal support and tight state budgets.

The major problem in veteran access to Medicaid is the categorical eligibility orientation of the program. Unless a veteran falls in one of the specific categories—Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI)—he or she would not qualify for Medicaid. Medically-needy options, which some states provide within their Medicaid programs, have slightly higher income thresholds than AFDC or SSI but still are grounded in categorical eligibility.

> ***"The major problem in veteran access to Medicaid is the categorical eligibility orientation of the program."***

Despite this, Medicaid would represent a line of financial support for a portion of aged, blind, or disabled displaced veterans. In some states, it would provide a broad range of services and include access to certain types of community-based social and health related services which VA does not currently provide throughout its system.

Public hospital care is limited in the areas in which it is available. With rare exceptions, it is an option for poor veterans but not one with comparable programs and services, especially in the areas of chronic care.

REVERSE COST SHIFTING AND AVOIDANCE

Pressures on the non-VA health care system to minimize costs for inpatient care will foster a different kind of cost shifting, one that leads from Medicare, Medicaid, and the private sector to the VA.

Under provisions of Medicare's prospective payment system (PPS), non-VA hospitals and payers are under severe financial pressures to avoid expensive and long term treatment of recipients. State Medicaid programs, always short of funds, are eager to find alternative sources of payment for the medically needy. Hospitals have strong incentives to avoid treatment of non-paying patients.

> ***"These factors combine to create an environment in which such parties may increasingly look to the VA as an alternative source of care and financing, and make active efforts to transfer high cost or indigent veterans to VA care."***

These factors combine to create an environment in which such parties may increasingly look to the VA as an alternative source of care and financing and make active efforts to transfer high cost or indigent veterans to VA care. The inclusion of nonservice-connected veterans with income under $15,000 in Category A under Public Law 99-272 will stimulate additional shifting of this kind, since the space availability factor no longer appears to govern VA's acceptance of such patients for hospital inpatient care.

This effect has been suggested in a recent study which demonstrated there has been a marked increase in discharges from VA hospitals in 21 DRGs identified as "problem DRGs" by private hospitals. The results lead the authors to conclude that, "Hospital costs may have simply been shifted from Medicare to the VA system—resulting in no net savings to the government as a whole."

In addition, the voluntary shift from Medicare to VA care by elderly veterans who find the increasing out of pocket costs associated with Medicare unaffordable can be expected to accelerate. The limited Medicare benefit for nursing home and home health care will also result in increasing numbers of veterans looking to the VA as a resource.

HEALTH PROFESSIONS EDUCATION AND RESEARCH

Since the post-WW II period, VA Medical Centers have become integral parts of the health training and research capacity in the U.S. through affiliations with health professions teaching institutions. The importance of the relationship to both parties, and the harmful effects that closure of an affiliated tertiary care VAMC would have on the affiliated institutions' educational and research activities, were clear in the districts studied.

In each of the study districts, there were tertiary care VAMCs with substantial affiliation relationships with one or more medical schools as well as with other health professions training programs. Although both parties clearly benefit from these relationships, the relative benefit varies between districts and among affiliations.

The effects of closure of tertiary care affiliated VAMCs on the involved medical schools would be substantial. Medical schools are already beset by decreased financial support from the federal level as well as the effects of the prospective payment system (PPS) for Medicare and the prudent purchasing practices of insurers and employers. These efforts to contain costs directly affect any medical school's main teaching hospital, where fixed payment per case tends to be inadequate for the heavier load of complex cases they admit. They also have an impact on local community hospitals which have traditionally sought affiliation.

"Medical schools are already beset by decreased financial support from the federal level as well as the effects of the prospective payment system . . . "

As the market in health care becomes more "competitive" and community hospitals come under increased pressure to contain costs, participation in education programs is being viewed on a cost-benefit basis and frequently cut back. In 1983, most of the affiliated medical schools in the study districts were obtaining more than half their clinical clerkships through affiliations with the VA, a figure that may increase in the future.

The VA affiliations with health professions schools provide students with an exposure to older patients and chronic illnesses which is difficult to obtain elsewhere. Given that today's professional trainees will increasingly need to work with older and disabled patients, the experiences gained in the VA are particularly relevant.

"Given that today's professional trainees will increasingly need to work with older and disabled patients, the experiences gained in the VA are particularly relevant."

Similarly, research in the basic and clinical sciences in VAMCs has grown apace with the growth of affiliations. Each of the tertiary care VAMCs in this study conduct multi-million dollar research programs using both VA funds and substantial grants from other sources. VAMCs are also sites for sponsored research carried out by faculty of affiliated training programs. The VA's ongoing contributions in geriatric research are particularly important in view of the aging of the population. The numbers of older patients in the VA who participate in research studies cannot be duplicated in other components of the U.S. health care delivery system at the present time.

VARIABLE DOD SUPPORT CAPABILITY

Downsizing of certain VA Medical Centers in the districts studied would have serious effects on the DOD support mission which has been assigned to the VA.

Each medical district participates in a planning process to provide a contingency backup to military medicine in times of national emergency. Assignments vary with location, level of services, and need for support of specific military installations.

The planning process requires that a suitable capacity be maintained to handle service-connected veterans as well as military casualties during any period of emergency. Thus, not all beds at all VAMCs are available, nor do they fall in the categories of service required by DOD. Accordingly, VAMCs are not interchangeable in their backup roles.

The district studies show certain closures would directly affect the VA mission in support of DOD. It is clearly possible in the case of some closures to maintain the number of beds required by DOD without affecting service-connected veteran access to VA services. The effectiveness of DOD backup, however, has a geographic element as well as a capacity element. VAMCs assigned primary receiving responsibilities must be close to an entry point such as an airport or Air Force base. Other VAMCs assigned base support functions must be located in reasonable proximity to a military installation. Still others provide special services which could not be duplicated in another facility in the district.

"The district studies show certain closures would directly affect the VA mission in support of DOD."

There is an additional issue which has arisen as a result of passage of Public Law 99-272, and which is not resolved. Since entitlement under Category A does not discriminate between service-connected veterans and low income veterans for inpatient hospital services, the planning model used in DOD contingency plans may have to be modified.

Epilogue

Proposed cutbacks in VA health care resources come at a critical time for veterans. The veteran population is aging rapidly, presenting different health care needs. More, not fewer, resources will be required to meet the nation's commitment to these older veterans. The non-VA health system is changing in ways which may make it more difficult for poor veterans and older veterans to obtain needed health care from non-VA sources.

This report is about interactions. There is an American health care delivery system, no matter how loosely organized, and the VA is a part of that system. The VA health care system does not stand apart, thus lending itself to totally independent study. There have been many studies of the VA medical care mission performed by the VA itself as well as by many other governmental agencies and commissions. Few deal with the effects of changes inside the VA component on the rest of the health care system. Fewer still deal adequately with implications of changes in the scope and organization of the VA component for shifting costs and responsibility for care of veterans to other parts of society. And fewest of all deal with the effects of policy changes on the health care of individuals.

The questions raised by this study should be of concern not only to veterans and their traditional supporters, but to a wide range of policymakers at every level of government. If current efforts to cut back on veterans' health services are successful, then those currently served by the VA must seek the health care they need in the non-VA sector. This requires resources, and, for those veteran users without their own financial resources, another source of financing. If these individuals are to receive needed care, other federal, state, and community resources will increasingly be called upon to substitute for the "saved" VA resources.

Veterans' health care—who gets it, who gives it, and who pays for it—will increasingly become an issue for states, communities, and the federal government, as well as for society at large.

Acknowledgements

Paralyzed Veterans of America wishes to acknowledge the contributions of the advisors to this project. Their advice and assistance in the development of the study methodology and review of the documents was invaluable. To each of them we offer our gratitude.

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The Statement of

DAVID J. PASSAMANECK

AMVETS National Legislative Director

Before The

COMMITTEE ON VETERANS' AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

On

The President's Proposed Budget for the Veterans'
Administration for Fiscal Year 1988

9:00 a.m., February 3-4, 1987

Room - 334, Cannon House Office Building

AMVETS is pleased to present our views on the Administration's proposed budget for the Veterans Administration for Fiscal Year 1988.

The general attitude of the Administration toward the Americans whose military service has earned the entitlements and benefits which a grateful nation has provided, is to treat that group, our veterans and their families, as if they have no greater claim on budgetary resources than a myriad of government funded programs which, at least rhetorically, are to be subjected to stringent economizing in the name of deficit reduction. The government programs which comprise the greatest portion of ever expanding, largely out of control spending, are those programs which respond to the demands of politically powerful special interest groups who, in most cases, have no legitimate claim on the federal treasury, and a far less justified claim than veterans.

In one of its first initiatives, the 100th Congress has committed itself, over the President's strenuous objection, to spending $20 billion to subsidize the cost of the operation of local sewer treatment and water purification projects, largely to the benefit of the manufacturers of sewage treatment equipment, and local governments which do not have budget deficits. The continuing hemorrhaging of our national resources to artifically inflate the price of farm products and to store the surpluses that result from price subsidies, has increased since 1979 by over 500%. But in the face of these and hundreds of other examples of irresponsible spending, the Administration insists on including veterans' programs among those which we are told must equally share in the burden of reducing the deficit. AMVETS rejects this insulting distortion of our national priorities and moral obligations. No matter what the exigencies of the federal budget process, and regardless of the organizational structure of the Executive Departments and the Congressional authorizing committee system, the Veterans Administration budget is an integral part of the cost of national defense, which is the most important function of government. It is too bad that so many of the conservative and pro-defense elements in the Administration and Congress cannot seem to understand this. We must stop classifying veterans' programs as undistinguishable from the general run of "domestic" expenditures and remember that the reason we have veterans and the reason they have disabilities and rehabilitative needs is the same reason why we must have a strong and effective national defense capability.

/The Veterans Administration budget for Fiscal Year 1988 calls for $27.6 billion to fund medical, compensation, and other programs for 27.6 million veterans, eligible members of their families, and survivors of deceased veterans. Although the request is nearly $550 million greater than the current FY 1987 estimated requirements this represents little more than keeping pace with the increasing cost of current services.

The 1988 budget provides $15.2 billion for benefits programs, $10.3 billion for medical programs and $525.7 million for construction. Total Agency full-time equivalent employment is expected to be 218,005, down 3,126 from that currently proposed for 1987. The VA claims that this loss will be absorbed by productivity improvement and a lower workload. However, they have never been able to demonstrate how, for example, two employees can serve their veteran consumers as efficiently and compassionately as five. Moreover, the predicted reduced workload may well be a self--fulfilling result of the cutting of services.

VA's $10.7 billion request for compensation payments is based on estimates that 2.2 million veterans with service-connected disabilities will remain eligible for monthly payments, along with 323,000 survivors of veterans who died of service-connected causes. The request provides for a 3.5 percent increase in compensation rates and additional legislation will be proposed indexing the annual compensation cost-of-living adjustment to changes in the Consumer Price Index. AMVETS, as it has in the past, remains opposed to the automatic indexing of compensation and DIC rates to the Consumer Price Index. The special needs of veterans based on their age classification and their proportionately intense requirement for health care, would not be equitably reflected in the general Consumer Price Index. Indexing compensation would also de-emphasize the current thorough evaluation of the compensation system which usually accompanies the legislative process of periodic adjustment, not only of rates, but of collateral compensatory factors such as presumptions and special entitlements. The periodic compensation bill usually serves as a useful vehicle for enactment of needed improvements in veterans' programs other than compensation and DIC.

We have no quarrel with a proposed reduction in readjustment benefits of about $136 million attributable to an anticipated lower number of eligible veterans. We do, however, strongly oppose a proposed increase in the VA home loan funding fee from 1 to 2.5 percent effective 1 June 1987. Anyone with experience in the ways of government will readily understand that this 150% increase, if enacted, will only be the first step in the eventual destruction of the loan guaranty program as one of the most universally beneficial and popular veterans' entitlements, and that a 1.5% increase to the origination fee will add $3,000 to the cost of the average $70,000, 30-year VA fixed mortgage, will not be applied to current VA programs, but revert to the Treasury, and will drive the younger, first-time veteran buyer from the housing market. The Administration is also proposing to remove the interest rate limit for VA guaranteed loans, requiring veterans to negotiate rates with lenders. This proposal can only inure to the benefit of the mortgage industry at the expense of veterans who are borrowers. Consistent with the philosophy of the Grace Commission report, these proposals apply business management criteria to a program which was never intended to be operated as a private market profit and loss enterprise, but as an earned entitlement for veterans. If private sector standards are to be employed in the management of the VA loan guaranty system, sooner or later that system will be abandoned as duplicative of the private market.

The proposals for operation of the VA Department of Medicine and Surgery lead off with a shocking request for a $75 million rescission to eliminate funding that would otherwise be used during the last five months of Fiscal Year 1987 for the health care of "higher income, nonservice-connected disabled veterans" (Category C) who are considered financially able to provide for their own health care. Although this rescission of funds already appropriated is designed to affect only the Category C, or lowest priority of veterans eligible for VA health care, the practical necessities of the medical care delivery system will result in this sharp reduction of resources adversely affecting both service-connected and indigent veterans as well. end VA beds are not, and cannot be, managed with A, B, and C labels. At any particular moment in time, patients are admitted to available beds not on the basis of eligibility category, but on the basis of medical need. If at a given moment, a facility has a bed available, that bed will be assigned to the next veteran whose medical assessment indicates admission is appropriate.

If the individual veteran concerned is a C case, he must pay the appropriate deductible. OMB seems intent on assigning a reduction on the basis of these eligibility categories--intent, in other words on excluding the B's and C's. However, the VA would possess no practical means to implement such policy. Instead, each facility would suffer some level of resources reduction, which would primarily affect overall resource capacity. The same variety of patients normally seen would still be present for care. Thus, on any given day, a B veteran might well be admitted to an empty bed. Empty beds would be assigned to patients on the basis of medical need, as before. The overall reduction in capacity which results from the rescission would serve to potentially bar access for some A's, some B's, and some C's, because that is the character of hospital operations. In this manner, the VA's performance as a result of the rescission undoubtedly would clash with the law, which denies the Administrator any discretion whatsoever to limit access to a VA bed for A Category veterans. During the period, October - December 1986, 690,809 veterans, or 94%, were Category A entitled and in need of care. These are bona fide health care needs of the poorest of the poor and sickest of the sick.

Although the VA budget calls for an overall increase of $548 million over FY 1987 authority, including over $400 million more for medical programs, $393 million of the medical increase will be absorbed by pay raises and retirement costs. The overall effect will be a shortage of more than $300 million required just to maintain current services. With one hand, this budget appears to provide for increased services, and with the other, it takes away more than the additions. While asking for $175 million for new facility activations, including 1,981 new FTEE, at the same time the budget projects a 1% productivity increase in this category, resulting in a loss of 1,991 FTEE in FY 1988. The overall loss of 3,126 FTEE, includes 2,631 (84%) from DM&S, most of whom probably will involve direct medical care staff, thus reducing in quality veteran health care. The net result of this legerdemain will be 6,200 fewer direct care VA health personnel, 113,000 fewer outpatient visits, and 13,500 fewer inpatients than authorized for FY 1987. In short, the VA will meet the challenge of the increasing numbers of aging veterans by excluding many of them from the system, and allowing services to deteriorate. To further compound this lamentable situation, a proposed conversion of 282 hospital beds to nursing home care will be offset by no new nursing home construction for FY 1988 and beyond. However, AMVETS has had no quarrel with the VA (or DM&S) on the issue of conversion at under-utilized medical centers. As we understand the situation, in this particular instance, conversion will take place at medical centers which actually could use the business. In addition, the proposed budget would restrict beneficiary travel allowances to only patients receiving health care at VA medical facilities who require medically indicated special modes of transportation. As a practical matter, this means that aging and indigent veterans will be precluded from seeking care at VA facilities located away from their home areas.

The loss of 296 FTEE for the Department of Veterans Benefits including 255 FTEE from the Compensation and Pension Division and 95 FTEE Veterans Benefit Counselors who respond to veterans inquiries and process veterans claims for benefits, will impose a greater burden on the Veterans Service Officers to "pick up" the slack. (71 AMVET National Service Officers, nationwide, made us the second largest National Service Organization in 1986 with 445,751 contacts [+35% over 1985] and 19% more Powers of Attorney.) The loss of 225 FTEE in medical research, an area in which the VA has always prided itself, and the loss of $102.3M for replacement and moderization of medical centers will result in further deterioration of facilities and equipment.

AMVETS has been proud to join with the Disabled American Veterans, the Paralyzed Veterans of America and the Veterans of Foreign Wars of the United States in formulating a detailed, independent budget proposal for the VA Department of Medicine and Surgery, copies of which have been widely distributed to include the members and staff of this Committee. This proposal calls for authorization of approximately $1.2 billion more than the Administration request and reflects what we believe to be the minimum acceptable level of medical service to veterans. Over $800 million of this increment represent uncontrollable expenditures and less than $400 million would be committed to initiative programs. We respectfully invite your consideration of this alternative, independent budget for DM&S.

MEETING THE CHALLENGE

An Independent Health Care Budget for Veterans

STATEMENT OF
DR. DONALD CUSTIS
BEFORE THE
HOUSE COMMITTEE ON VETERANS'AFFAIRS
CONCERNING
AN "INDEPENDENT BUGET" FOR VETERANS' MEDICAL CARE
DEVELOPED BY
AMVETS, DISABLED AMERICAN VETERANS
PARALYZED VETERANS OF AMERICA
VETERANS OF FOREIGN WARS
FEBRUARY 3, 1987

This is a veterans' budget for veterans. The AMVETS, Disabled American Veterans, the Paralyzed Veterans of America and the Veterans of Foreign Wars have joined in an unprecedented common effort to develop and propose to the Congress an independent FY 1988 budget for veterans' health care. Ours is a proactive effort to place on the record the perspective of the Congressionally-chartered consumer representatives of our nation's veterans.

The strategy. Several forces shape our proposal (Figure 1). For one, the workload of the VA health care system will increase because of newly-legislated eligibility changes, the aging of the veteran population, the growing number of uninsured and medically indigent Americans, and the decreasing willingness of the private sector to provide uncompensated care. Also, the dollars required to maintain the VA system as it stands, with no increase in treatment capacity, will increase substantially over time due to inflation, routine payroll related increases and commitment made to activate facilities under construction (Figure 2). In addition, this is a period of fiscal austerity with unprecedented federal budget deficits. The confluence of these forces requires the VA health care system to meet the challenge of a growing workload innovatively, optimizing resource use while also forging ahead in its missions in research, education of health care professionals, and provision of backup capacity to DOD in the event of military action.

A key feature of our strategy is to expand outpatient care in order to treat illness at the earliest point in time and to reduce the need for far more costly inpatient care. We propose a similar strategy for long-term care, where our emphasis on non-institutional modalities of care calls for expansion of innovative treatment methods such as hospital-based home care, geriatric evaluation units, and community residential care. Implementation of this general strategy now will result in considerable savings for the VA system over the long run.

Our inpatient strategy takes advantage of reductions in hospital length of stay by converting unneeded acute care beds to extended care use. However, we recommend maintaining most acute care staffing because an increase in staff per occupied bed is necessary to achieve the shorter stays. Extended care staff must be increased, and we recommend an emphasis on mid-level practitioners such as physician assistants and nurse practitioners. As well, it will be necessary to increase nursing home capacity with both new VA nursing homes and an expansion of the subsidized State nursing home program and the contract community nursing home program.

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Current services. Figure 3 shows the funding we recommend in the five appropriation accounts into which the VA health care budget is divided. Figures 4 and 5 indicate most of the dollar increases we propose are not for program expansions, but are required merely to keep even with rising costs. Enacted appropriations for VA health care for FY 1987 are $9,686 million, but over $300 million more in supplemental appropriations are required to maintain the envisaged level of VA health care activity throughout FY 1987. Over 90 percent of this supplemental amount is needed to fully fund the 3 percent federal employee pay raise of January 1, 1987, and the increased contribution required by the Federal Employees' Retirement System (FERS). The pay raise and FERS increase cost DM&S money, but do not bring it any added resources. If supplemental funds to cover these costs are not appropriated, DM&S will have to cut employment below the level Congress envisaged when passing the basic appropriations for FY 1987. That translates into reduced services. Nonpersonnel accounts cannot realistically absorb $300 million in cuts. These accounts are already severely strained by the $72 million that had to be absorbed in FY 1987 in order to maintain staffing and beneficiary travel funds. The strain shows in the $500 million plus backlog of needed equipment from which DM&S suffers.

As Figure 4 indicates, the FY 1988 current services level is, in turn, more than $500 million above the FY 1987 level, with most of the $500 million required for payroll-related increases and inflation. It should be noted that the payroll-related increases are predominantly for a further increase in required FERS contributions. Nothing is included for an FY 1988 pay increase, for we have felt we should not singlehandedly overturn the budget formulation rule that out-year pay increases are not included in the budget.

The FY 1988 current services level includes $205 million for activation of facilities whose construction will be completed in FY 1988. This covers both equipment and an increase of approximately 2,300 FTEE in personnel. Activations are included in current services because the alternative to equipping and staffing facilities -- namely, leaving newly-constructed or newly-renovated facilities empty and unused -- is absurd, particularly in a system suffering from the aging of so many of its facilities. Activations do provide some increase in treatment capacity -- about ½ of 1 percent for both inpatient and outpatient care, judging from recent years -- and we have taken this into account in sizing the initiatives we propose.

The primary point to remember about current services is that it will take an increase of more than $800 million over enacted appropriations for FY 1987 in order to provide in FY 1988 the level of services envisaged when these appropriations were made for FY 1987 (see Figure 5). This increase of over $800 million is more than twice the amount we propose for initiatives. Thus, the main cause of spending increases in our independent budget is keeping even with rising costs, not expansion of services.

In short, the budget we present to you today is very much a fiscally conservative one, honed down to the bare necessities for meeting the VA's role now and making some modest commitments to prepare the VA for the immediate future.

Initiatives. As Figures 4 and 6 show, the initiatives we recommend total just over $400 million. Almost $370 million of the cost of the initiatives is in the Medical Care appropriation, which provides 97 percent of VA health care funds. Our initiatives in Medical Care are sized according to the growth to be expected solely from the aging of the veteran population, without allowance for an increase in demand from the approximately 10 million "Category A" veterans newly-entitled to VA inpatient hospital care under Public Law 99-272. VA data to date does not show a large expansion in demand from this group. Although we suspect problems in the data, we have been fiscally conservative and thus have not built in an increase from this source. However, as these veterans learn of their entitlement more of them will seek VA care. Similarly, as public programs and private hospitals learn of the entitlement, they will send more and more uninsured veterans to the VA. Thus we call upon the Congress to be ready to appropriate additional funds if additional demand, due to the Public Law 99-272 expansion of entitlement, does occur in FY 1987 or FY 1988.

The major initiatives (see Figures 4, 7 and 8) that we propose in the medical care appropriation are:

- ° Expansion of extended care both in innovative programs and in nursing homes at a net cost of $108 million and an addition of 360 FTEE. Although we are shifting the balance of extended care toward innovative programs, most of the cost increase, nonetheless, is for nursing homes. We note that many states have a freeze on private nursing home construction and are disinclined to expand or establish state veterans' nursing homes. Thus, in the long term, much of the VA's expansion in nursing home census must come from the VA's own nursing homes. We recommend construction funding for 12 VA nursing homes this year to provide some of the needed expansion in capacity.

- ° Provision of 400 thousand additional outpatient visits, an increase of just over 2 percent, at a cost of $30 million and with an increase of 600 FTEE.

- ° An increase of approximately 2 percent in the number of inpatients treated at a cost of $75 million and with a staffing increase of almost 1900 FTEE.

- ° An increase of $11 million in funds for continuing education to keep VA staff up-to-date with the many and rapid changes that take place in health care. These funds have been severely eroded in the last decade while the rapid changes in care continue.

- ° An increase of 200 FTE and $9 million in traineeships to augment VA house staff and VA recruiting ability in specialties in which the VA is plagued by particularly severe staff shortages.

- ° $50 million for ADP equipment as part of a multi-year effort to bring the VA health care system up to date in data processing after years of starvation. We caution against plans that we understand the VA has to change the nature of the computer system in mid-stream. We fear that a major change made now may lead to a breakdown in the ADP development program.

- ° $90 million to restore funds for reimbursements to patients entitled to payment of their costs of travel to and from VA medical centers and for the costs of transferring patients between VA health care facilities.

Our proposed initiatives in Research, as shown in Figures 4 and 9 include:

- ° Augmentation of rehabilitation research by $3 million to a total of $20 million in FY 1988. Rehabilitation research is a field in which the VA has a national leadership role and a special obligation to the millions of veterans with disabilities, many of them service-connected.

- ° An addition of $2 million to health services research. Health services research is directed at improving the effectiveness and efficiency of the health care system. the $11 million total recommended is about 1/10 of one percent of the VA health budget, a very small sum in this era of tight budgets when inefficiency is least tolerable.

- ° An increase of $4.6 million in medical research. Most VA medical research is carried on by clinicians and thus has a high relevance to the particular needs of veterans and VA patients.

Staffing at the Washington headquarters of the VA health care system has been cut by almost one-third in recent years. We are concerned that this leaves inadequate staff for sound management, particularly in an era when waste due to mismanagement can least be tolerated. Thus, we recommend a study of Central Office staffing and organization. In the Medical Care and Miscellaneous Operating Expenses (MAMOE) appropriation, we also recommend (as shown in Figures 4 and 10):

- ° Reactivation of the health professionals scholarship program in nursing and other shortage professions with $6 million in FY 1988. The program has provided an important assist in dealing with the VA's nursing shortage problem.

- ° Funding of a new, legislatively-mandated quality assurance system that will focus on patient care outcomes and quantitative data.

Finally, we recommend an increase of over 40 percent in grants to states for construction of extended care facilities. The state-sponsored veterans' nursing homes that these grants help to build provide care to veterans at a very low cost to the VA. A major component of our extended care strategy is to take full advantage of states' willingness to expand the network of these homes. The increase in funds recommended for FY 1988 is based upon "pre-applications" already recieved from states.

We recommend these initiatives as the minimum necessary for the VA to contain costs, to improve its efficiency, to continue to play its role in meeting the increasing care needs of those who served their nation in the armed forces, to maintain quality of care, and to fulfill its missions in research, health professionals training, and DOD backup.

THE ISSUES

Figure 1

- AGING VETERAN
- BUDGET FORMULATION PRACTICES
- HEALTH CARE SYSTEMS INTERACTIONS
- ADVANCES IN TECHNOLOGY

THE UNCONTROLLED ENVIRONMENT

Figure 2

- PAY INCREASES
- FEDERAL EMPLOYEES RETIREMENT SYSTEM
- INFLATION
- ACTIVATIONS
- TECHNOLOGY ADVANCEMENT

Figure 1

MEDICAL APPROPRIATIONS AND FUNDS

SUMMARY OF APPROPRIATION REQUIREMENTS
(dollars in thousands)

Appropriation Account	1987 Enacted Appropriation	1987 Current Services	1988 Current Services	1988 Recommendation	Increase(+) Decrease(-) from '87 appropriation
Medical Care					
obligations		$9,780,817	$10,315,971	$10,684,455	
minus reimbursement		60,000	60,000	60,000	
appropriation	$9,411,817**	9,720,817	10,255,971	10,624,455	+ 1,212,638
Medical and Prosthetic Research					
obligations	189,915*	201,915	212,124	220,674	
minus reimbursement		5,200	5,200	5,200	
appropriation		196,715	206,924	215,474	+ 25,559
Medical Administration and Miscellaneous Operating Expenses:					
Medical administration	41,194	42,426	42,624	43,974	+ 1548
Postgraduate and inservice training	...	...	...	...	
Health professional scholarship	...	...	...	6,000	
Subtotal	41,194	42,426	42,624	49,974	+ 8,780
Grants for Construction of State Extended Care Facilities	42,400	42,400	42,400	60,000	+ 17,600
Grants to the Republic of the Philippines	500	500	500	500	-0-
Total	$ 9,685,826	$10,002,858	$10,548,419	$10,950,403	+ 1,264,577

**Includes [illegible] million DOD transfer.

RECOMMENDED DEPARTMENT OF MEDICINE AND SURGERY BUDGET
(dollars in thousand)

FY 1987	Enacted Appropriations*		$ 9,685,826
FY 1987	Estimated Obligations (+$65,200 Reimbursements)		9,751,026
FY 1987	Supplemental Funds Required		
	Payroll Increases		132,524
	Health Benefits		27,641
	Federal Retirement System		156,867
FY 1987	Current Services Level		10,068,058
FY 1988	Payroll Related Increases		348,307
	Inflation		182,650
	Facility Activations		205,000
	Decreases in Capital Investment		(199,000)
	Other		8,604
FY 1988	Current Services Level		10,613,619
FY 1988	Initiatives		
	Medical Care		
	Extended Care	108,000	
	Inpatient Hospital Care	75,602	
	Outpatient Care	30,000	
	Continuing Education	11,200	
	Traineeships	9,000	
	ADP Equipment	50,000	
	Beneficiary Travel	30,000	
	Interfacility Transport	60,000	
	Other (net)	(5,318)	
	Total Medical Care		368,484
	Medical and Prosthetic Research		
	Rehabilitation Research	3,000	
	Health Services Research	2,000	
	Medical Research	4,600	
	Other (net)	(1,050)	
	Total Medical and Prosthetic Research		8,550
	MAMOE		
	Management Study	150	
	Health Professional Scholarship	6,000	
	Quality Assurance System	1,200	
	Total MAMOE		7,350
	Grants for Construction of State Extended Care Facilities		17,600
	Reimbursements		(65,200)
FY 1988	Recommended Appropriation		$10,950,403

*Excludes $10.4 million from HHS transfer.

Figure 4

RECOMMENDED DEPARTMENT OF MEDICINE AND SURGERY BUDGET

(DOLLARS IN THOUSANDS)

• FY 1987 ENACTED APPROPRIATION*	$ 9,685,826
• FUNDS TO MAINTAIN 1987 SERVICES	+ 862,593
• INITIATIVES	+ 401,984
• TOTAL FY 1988 RECOMMENDED APPROPRIATION	$10,950,403

*EXCLUDES HHS TRANSFER OF $10.4 MILLION

MEDICAL CARE

(DOLLARS IN THOUSANDS)

1987	APPROPRIATION	9,411,817*
	REIMBURSEMENTS	60,000
	ADDITIONS REQUIRED	309,000
1987	CURRENT SERVICES LEVEL	9,780,817
	PAYROLL INCREASE	339,000
	OTHER UNCONTROLLABLES AND MISCELLANEOUS	196,154
1988	CURRENT SERVICES LEVEL	10,315,971
	INITIATIVES	+368,484
	REIMBURSEMENTS	(60,000)
1988	RECOMMENDED APPROPRIATION	10,624,455

*EXCLUDES $10.4 MIL FOR HHS TRANSFER

Figure 7

MAJOR PROGRAM TARGETS

	FY 1987	FY 1988 NEED	1990 TARGET
• HOSPITAL PATIENTS TREATED	1,309.0 K	1,349.0 K	1.7 MIL
• VA NURSING HOME - ADC	11.0 K	12.5 K	15.5 K
• COMMUNITY NURSING HOME - ADC	12.0 K	16.0 K	19.0 K
• AMBULATORY CARE - VISITS	18.5 MIL	18.9 MIL	23.4 MIL
• INNOVATIVE LTC PROGRAMS			
- HOSPITAL BASED HOME CARE (VA)	52	65	76
- GERIATRIC EVALUATION UNITS	60	80	172
- RESPITE CARE PROGRAM	1	41	172
- ADULT DAY HEALTH CARE (VA)	8	20	76
- GERIATRIC RESEARCH EDUCATION AND CLINICAL CENTERS	10	13	25

FY 1988 EXTENDED CARE INITIATIVES
(DOLLARS IN THOUSANDS)

• VA NURSING HOME	($23,000)
• COMMUNITY NURSING HOME	+81,700
• HOSPITAL BASED HOME CARE PROGRAMS	+ 3,512
• ADULT DAY HEALTH CARE PROGRAMS	+ 8,091
• COMMUNITY RESIDENTIAL CARE PROGRAMS	+ 1,779
• GERIATRIC EVALUATION UNITS	+ 2,884
• GERIATRIC RESEARCH EDUCATION AND CLINICAL CENTERS	+ 7,482
• RESPITE CARE PROGRAMS	+ 309
• HOSPICE CARE PROGRAMS	+ 2,472

MEDICAL AND PROSTHETIC RESEARCH
(DOLLARS IN THOUSANDS)

1987	APPROPRIATION	189,915
	REIMBURSEMENTS	5,200
	ADDITIONS REQUIRED	6,800
1987	CURRENT SERVICES LEVEL	201,915
	PAYROLL INCREASE	7,959
	OTHER UNCONTROLLABLES AND MISCELLANEOUS	2,250
1988	CURRENT SERVICES LEVEL	212,124
	INITIATIVES	+8,550
	REIMBURSEMENTS	(5,200)
1988	RECOMMENDED APPROPRIATION	215,474

Figure 9

MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES
(DOLLARS IN THOUSANDS)

1987	APPROPRIATION	41,194
	ADDITIONS REQUIRED	1,232
1987	CURRENT SERVICES LEVEL	42,426
	PAYROLL INCREASE	1,348
	OTHER UNCONTROLLABLES AND MISCELLANEOUS	(1,150)
1988	CURRENT SERVICES LEVEL	42,624
	INITIATIVES	+7,350
1988	RECOMMENDED APPROPRIATION	49,974

Figure 10

STATEMENT OF THE HONORABLE TIM JOHNSON
CONGRESSMAN AT LARGE, SOUTH DAKOTA

HOUSE COMMITTEE ON VETERANS AFFAIRS
February 3, 1987

Mr. Chairman, I have a number of concerns about veterans affairs in general and the Veterans Administration's FY 1988 budget in particular.

I come from a rural district that comprises an entire state. Although there are three VA hospitals in South Dakota, the distances some veterans have to travel for health care are formidable. I am concerned that last year's elimination of beneficiary travel will put undue hardship on many of my constituents, and in some cases dissuade them from seeking the VA health care to which they are entitled. Previously veterans were allowed eleven cents per mile when traveling to VA health centers. That allowance has been eliminated, and now many stay away from the hospitals and their conditions deteriorate. I feel that eliminating the federal deficit is a high priority, but this is not the way to do it.

The Veterans Administration's FY 1988 budget does little to improve the situation. Although the budget authorizations are highest in history, they simply are not keeping pace with the needs of our veterans. This budget is $160 million short of what is required just to maintain current services...and services are likely to need a big boost in the near future. The graying of America is being mirrored in South Dakota, and our veterans are aging as well. The need for nursing home care for veterans will skyrocket in South Dakota as in the rest of the country, and this budget is not farsighted in its approach to this problem.

I question whether this budget has the best interest of the veteran at heart, whether it is based on human considerations or puts more emphasis on budgetary considerations. I hope this committee will submit a budget that maintains and improves benefits for our veterans.

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202-861-6500

Mortgage Bankers Association of America

STATEMENT OF THE

MORTGAGE BANKERS ASSOCIATION OF AMERICA

for submission to the

COMMITTEE ON VETERANS' AFFAIRS

of the

UNITED STATES HOUSE OF REPRESENTATIVES

For the Record

on

The Fiscal Year 1988 Veterans Administration Budget

February 3, 1987

The Mortgage Bankers Association of America* submits this statement on the Administration's proposed budget for the Veterans Administration (VA) for Fiscal Year (FY) 1988, especially the provisions of that budget that call for the imposition of a 2.5 percent "user fee" for the VA home loan guaranty program and the provisions that would revoke the authority of the Administrator to set maximum interest rates for loans guaranteed in the VA home loan program.

In addition, MBA would like to comment on the Administration's budget proposals to amend current law in order to reduce the percentage of sales of VA acquired properties financed with vendee loans, to sell approximately $900 million of VA loans without recourse in the period FY 1988-1991, and to extend the 1 percent fee on VA-guaranteed loans (which is due to expire on September 30, 1987). MBA also will address the potential impact of the Administration's proposed changes for programs administered by the Government National Mortgage Association (GNMA), the Federal National Mortgage Association (FNMA), and the Federal Home Loan Mortgage Corporation (FHLMC) on the VA home loan guaranty program.

MBA also will make recommendations on the current VA no-bid problem, on adjustable rate mortgages (ARMs), and on an increase in the maximum guaranty amounts.

Any review of the VA home loan guaranty program must begin with a consideration and a rejection of the increase in the funding fee proposed by the Administration in its FY 1988 budget. The President's 1988 Budget proposes to increase the VA funding fee to 2.5 percent effective June 1, 1987.

President Reagan has steadfastly said that he would not increase taxes. With this proposed fee increase, he contradicts himself. The proposed fee is not only a tax on veterans seeking to own a home, but is contrary to the whole purpose of the VA home loan program. The proposed fee is more than a tax, it is an indirect effort to undercut the decision of Congress, reviewed and revised as recently as last fall, to recognize veterans' service by helping veterans to own their homes. If additional taxes are needed, they should be broad-based and not targeted to veterans or any other highly specific group. MBA urges that the Administration's proposed increase in the VA guaranty fee be rejected.

MBA believes that the VA home loan guaranty program is an excellent one and that the VA has operated the program well. The program is not perfect and it can be improved.

MBA has worked jointly with the VA to assist the VA in adapting the home loan guaranty program to current economic conditions where there is a relatively low rate of inflation in home sales prices. In October 1986, Congress passed legislation, the "Veterans Benefits Improvement and Health-Care Authorization Act of 1986" (P.L. 99-576), amending the home loan guaranty program. That act included some changes that MBA had recommended the VA adopt administratively. It called for tighter credit underwriting requirements and working with lenders in establishing uniform qualifications for appraisers doing appraisals for the VA.

There are some additional adjustments that MBA believes should be made to the home loan guaranty program. The VA should be authorized to guarantee adjustable rate mortgages (ARMs) with such limits, if any, as the Administrator deems necessary. The program should accept mortgage interest rates that are negotiated between borrower and lender, and not limited to interest rates that are administratively set. And, with respect to vendee loans, the Administrator should be able to make the best deal possible when selling properties acquired by the VA.

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*The Mortgage Bankers Association of America is a nationwide organization devoted exclusively to the field of housing and other real estate finance. MBA's membership comprises mortgage originators and servicers, as well as investors, and a wide variety of mortgage industry-related firms. Mortgage banking firms, which make up the largest portion of the total membership, engage directly in originating, selling, and servicing real estate investment portfolios. Members of MBA include:

- Mortgage Banking Companies
- Commercial Banks
- Mutual Savings Banks
- Savings and Loan Associations
- Mortgage Insurance Companies
- Life Insurance Companies
- Mortgage Brokers
- Title Companies
- State Housing Agencies
- Investment Bankers
- Real Estate Investment Trusts

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With respect to the VA no-bid situation, changes should be made that would reduce the number of no-bids that are caused by delays in the foreclosure process. In particular, Congress should delegate foreclosure authority to lenders in order to reduce delays, and accrued interest should not be included in the no-bid formula in certain cases where there are delays in the foreclosure process. These include avoidable delays caused by the VA after the lender is ready, willing, and able to foreclose; unavoidable delays, such as bankruptcy; and delays caused by forbearance.

Mortgage bankers are proud of the fact that they have participated in making a program work that has helped 11.6 million American veterans become homeowners and are concerned that the program continue to be operated in the most effective way possible.

THE PROPOSED INCREASE IN THE FUNDING FEE SHOULD BE REJECTED

The President's Budget for FY 1988 calls for an additional 1.5 percent "fee" to be added to the 1 percent funding fee currently being collected from veterans. The President's FY 1988 Budget (Appendix, page I-Y18) estimates funding fee collections would increase in 1988 by $360.8 million. The Administration projects these fees would be large enough to cover projected losses from defaults and obviate the need for future appropriations. The change would be effective on June 1, 1987, before the current fee expires on September 30, 1987, and would be made permanent.

If Increased Taxes Are Needed to Reduce the Deficit, They Should Not Be Targeted to Homebuying Veterans

It may well be that new taxes will be necessary to allow the Government to reduce the Federal budget deficit in FY 1988, but those taxes should be broad-based and should be decided upon in an open discussion of tax policy. The 2.5 percent user fee proposal is a back-door levy on homebuying veterans, thinly disguised as a cost-related user fee intended to strengthen the program.

The 2.5 percent fee proposed by the Administration would be a significant tax increase for the homebuying veteran. The average VA mortgage is $75,000. The current 1 percent fee amounts to $750. A 2.5 percent fee would amount to $1,875, an increase of $1,125 in closing costs. This 150 percent increase would create eligibility problems for the veterans who most need the VA home loan guaranty program.

The increase in the funding fee also could aggravate the current no-bid crisis faced by lenders in certain areas of the country. On a $60,000 property with no downpayment and a 2.5 percent guaranty fee, the mortgage amount would be $61,500. In areas subject to fluctuating economic conditions, the fair market value of the property could decline. For example, at a time when the mortgage principal has been reduced to $61,000, the property could be appraised at only $40,000. In case of foreclosure, the additional amount of the financed fee (which increases the amount of total indebtedness), when the necessary calculations are made, could tip the scale and create a no-bid.

The Fee Would Increase Borrowing Costs to Veterans

The VA has indicated that veterans would be allowed to include the funding fee in the principal balance of the loan. Using this approach, the 2.5 percent fee would be paid by the lender to the VA at the time the mortgage was originated, and the veteran would pay back this advance, with interest, over the life of the loan. Based on historical data, MBA has calculated the amount of the average VA-guaranteed mortgage to be $75,000, on which the proposed additional fee would be $1,125. The extra payments, over the 30-year term for which VA-guaranteed mortgages typically are written, would add approximately $3,100 to the borrower's costs. This additional expense to the borrower of the average mortgage amount is an arithmetical calculation based upon an interest rate of 8.5 percent, which was the administratively allowed rate when the calculations were made.

Averages are not the only way to understand the adverse impact upon the cost to veterans that adoption of the proposed increase in the fee would have. In fact, the hardest hit veterans would be those in the lower income ranges. The VA has a procedure whereby marginal cases are specially reviewed prior to being approved. Marginal cases are those where the veteran is stretching to buy a home. In calendar year 1984, approximately 60 percent of VA's marginal prior approval cases were for mortgage amounts that were less than the average mortgage amount. The impact of the increased cost of the higher fee will affect most severely those borrowers who are on the margin and who are struggling to achieve homeownership by the use of the VA program.

The Fee Would Threaten the No-Downpayment Feature of the Program

The VA has indicated that it will allow veterans to pay the proposed increase in the funding fee directly to the VA in cash, or allow lenders to advance the fee on the veteran's behalf and add the advance onto the original balance of the loan. If such inclusion in the loan is not fully and continually allowed, the effect is the same as requiring a downpayment of 2.5 percent. Because the inclusion of a 2.5 percent fee in the principal amount of the mortgage could make the total housing debt of the veteran more than the resale value of the house, the VA may find it impossible to continue to allow the fee to be financed.

The Fee is a Transfer of Burden

In proposing that homebuying veterans should increase their mortgage debt by the amount of the proposed additional funding fee, the Administration is asking veterans to shoulder the burden of expenses brought about by veterans who entered the home loan guaranty program at an earlier time. This is another reflection that the proposed fee is not user-cost related. Moreover, it shows a willingness on the part of the Administration to transfer the government's burden of general obligations, entered into in the past, to a targeted group of borrowers who are not specifically benefiting from those obligations.

Furthermore, current borrowers are subject to the recently enacted requirements to tighten the VA home loan program, yet these very borrowers would also have to cover losses attributable to veteran borrowers who received loans prior to those program changes, if the funding fee is increased to 2.5 percent.

The Fee Is an Attack on the Program

Beginning in 1981, the Reagan Administration has consistently demonstrated that it believes the Government should discontinue its commitment to support the homeownership aspirations of Americans. In 1981, the Administration proposed a roll-back and elimination of the Federal Housing Administration (FHA) mortgage insurance program and the GNMA guaranteed mortgage-backed security (MBS) program. Congress disagreed. In 1984, the Administration proposed a scheme under which the VA would make lenders dispose of all properties after default, even after the Administration had been warned that such a drastic and retroactive change could wreck the program. Congress would not allow it.

In 1985, the Administration began practicing the political tenet that "the power to tax involves the power to destroy." By proposing a 5 percent tax in 1985, then a 3.8 percent tax in 1986, and now a 2.5 percent tax in 1987 on the users of the VA home loan guaranty program, the Administration appears to be trying to accomplish indirectly what it cannot achieve directly: a diminution and even a phasing out of the VA home loan guaranty program.

MBA strongly urges that this Committee and the Congress reject the proposed increase in the funding fee for the VA home loan program.

VENDEE LOANS

The Administration's 1988 Budget (Appendix, page I-Y16) indicates that the VA would sell vendee loans in all cases without recourse. MBA opposes that proposal. Sale of vendee loans without recourse shifts the credit risk of default from the VA to the private purchasers, who necessarily adjust their purchase prices accordingly. Because of its size, and because it is the lender, the Government is a more efficient manager of vendee loan credit risk than any private buyer can be. Therefore, it can be expected that the reduction in the sales price paid to the Government by the private industry buyers of vendee loans will be greater than the savings the Government might realize by transferring the risk of default.

It is important to note that vendee loans sold with recourse can be put into mortgage pools backing GNMA securities. If these loans are sold without recourse, it is doubtful whether they could be put in GNMA pools. This means the loans would be sold at outrageously low prices or not at all.

In the "Deficit Reduction Act of 1984" (PL 98-369), limitations for vendee loans were set for the VA so as to minimize the number of vendee loans to the greatest extent consistent with maintaining the effective functioning of the VA home loan guaranty program. At least 60 percent of the purchases by private buyers of property acquired by the VA are required to be financed by the VA, with the maximum set at 75 percent. The President's FY 1988 Budget proposes to reduce this limitation on the number of vendee loans to between 40 and 60 percent of such sales. MBA urges that the quota concept be removed, and that the VA be allowed to use guaranteed vendee loans as fully as it deems economically advantageous in selling property acquired in the home loan guaranty program.

FREE VA INTEREST RATE

MBA supports legislation that would free VA loans from any interest rate controls, including the regulation of either interest rates or discount points. Under current law, the maximum interest rates on VA loans are set by the VA Administrator. These rates, however, historically have not accurately reflected the market rate for mortgages. If the maximum VA interest rate is too low, then home sellers often must pay substantial discount points to raise the yield on the mortgage to the level set by forces of supply and demand in the secondary mortgage market. Analysis suggests that a major portion of these discount points are effectively paid by the buyer in the form of a higher price for the property.

Since 1983, the interest rates on FHA-insured mortgage loans have been determined by the market. The VA home loan guaranty program is put at a disadvantage if the VA does not track the market closely. Sellers may refuse VA financing as an alternative because of the spectre of their having to pay substantial discount points if the VA sets its rate too low. Furthermore, to take advantage of the GNMA MBS program, lenders may have to place VA and FHA loans in separate pools if their interest rates are more than 1 percent apart. Although VA has been quite responsive to market forces over the past several years in making interest rate changes, a free rate would ensure the most efficient operation with the secondary market and minimize disruptions in the availability of mortgage credit to veterans.

EXTENSION OF THE FUNDING FEE

The VA home loan guaranty program has always been an entitlement program. When Congress created the VA home loan guaranty program in 1944 to assist veterans returning from World War II to buy a home, Congress did not design it or intend it to be supported by user fees. The program was a recognition by a grateful nation that the men and women who had forgone civilian life to defend the vital interests of the country should be aided in achieving homeownership. The program was partial payment for services performed.

The program became a commitment to young persons who entered military service in subsequent years to protect the vital interests of the nation in Korea, Vietnam, and elsewhere. That commitment has been reviewed from time to time, and Congress has always determined to renew it, the latest review being only a few months ago.

From the beginning, there was a realization that the program would need appropriations, and appropriations have been made in several fiscal years during the operation of the program. In 1984, Congress was faced with the fact that the economic cycle and certain changes in other VA operations precluded the VA from funding the home loan guaranty program from internal VA sources, and that appropriations would be required to continue the program.

At that time, Congress considered whether to renew its commitment to qualified veterans, especially the Vietnam veterans who are now reaching the point in their lives when they are ready to buy a home. The requested authorization and appropriations were granted; the VA was directed to administer the program in certain ways to reduce costs; and a 1 percent temporary funding fee was established, but scheduled to expire September 30, 1987.

Given the President's Budget proposals for FY 1988, Congress should reexamine whether the purpose of the VA home loan guaranty program is the same now as it has been for more than 40 years. The program was never designed to be actuarially sound, but to guarantee a mortgage loan to any qualified veteran, with no downpayment required. From the time the VA initiated its home loan guaranty program in 1944 until the end of 1985, 11.6 million loans had been guaranteed. The vast majority of those loans have cost taxpayers only the administrative costs of processing the initial approval. Only 4 percent of those loans have resulted in foreclosure.

Because the temporary funding fee expires at the end of FY 1987, Congress should review whether it wishes to continue the program as an entitlement.

IMPACT OF PROPOSED CHANGES IN GNMA, FNMA, AND FHLMC PROGRAMS

Government National Mortgage Association

GNMA has announced an increase in its mortgage-backed security guaranty fee from 6 to 10 basis points, which is a 67 percent increase, effective March 1, 1987. GNMA securities are backed by pools of VA mortgages, as well as FHA mortgages.

This GNMA fee increase will be passed onto veteran homebuyers. It is estimated that on a $70,000 mortgage, the GNMA fee increase would amount to an additional $187 in closing costs.

Lenders cannot absorb the cost of the additional fee. The cost of servicing a loan has greatly increased in recent years, i.e., 86 percent between 1979 and 1985. The cost of servicing GNMA pools is expected to have risen again in 1985 and 1986, particularly in economically distressed areas.

Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation

The number of VA mortgages that are pooled to back securities issued by FNMA and FHLMC is small. However, veterans would be affected by proposed changes in FNMA and FHLMC programs to the extent that VA loans back their securities. The Administration would freeze FNMA and FHLMC loan purchase limits at the lesser of the current $153,100 limit or no higher than the 75th price percentile of home sales in each sales market. The purchase limit was increased January 1, 1987, and reflects the 14.9 percent increase in home prices during FY 1986.

MBA opposes the proposal to freeze or reduce these limits. Doing so would prevent many homebuyers in many high-cost metropolitan areas from purchasing homes.

INCREASE IN GUARANTY MAXIMUM

MBA supports an increase in the maximum amount of the VA home loan guaranty. Such an increase would bring the relationship between the level of the guaranty amount and the ever-increasing cost of new and existing housing closer to historical ratios. The VA guaranty has not been raised since 1980. S 9, the "Service-Disabled Veterans Improvement Act of 1987," introduced on January 6, 1987, by Senator Alan Cranston, would increase the amount from $27,500 to $36,000.

Lenders ordinarily lend up to four times the guaranty amount, or up to $110,000, with no downpayment. In many areas, the applicable maximum allowable mortgage amount for VA does not reflect the realities of the housing marketplace. In those areas where the maximum amount is insufficient, homebuyers who might rely on the no-downpayment VA home loan program are deprived of this available financing vehicle. And, in many instances, these homebuyers have no other alternative sources of credit.

From 1974 to 1986, the median price of new single-family homes jumped from $35,900 to $92,000, an increase of 156.3 percent. Had the VA maximum guaranty been adjusted annually in equal proportion to the increase in new home prices, the 1986 guaranty would have reached $44,847 (Exhibit 1).

During the same period, the median price of existing single-family homes increased over 150.9 percent, from $32,000 in 1974 to $80,300 in 1986. Adjusting the VA maximum guaranty for annual increases in existing home prices for this period would have resulted in a maximum guaranty of $43,914 in 1986 (Exhibit 1).

EXEMPTION FROM SEQUESTRATION

With the enactment of the "Balanced Budget and Deficit Control Act of 1985" (PL 99-177) the parameters of the budget process, as it affects the smooth operation of the VA home loan guaranty program, are not as clear as they have been in the past.

Section 8 of S 9 would clarify the status of the VA home loan guaranty program. Benefits under this program would be specifically exempted from any sequestration order, or sequestration law enacted, for any fiscal year after FY 1986. MBA strongly supports this proposal and urges that Congress enact it into law.

ADJUSTABLE RATE MORTGAGES

MBA urges that the VA be authorized to include ARMs in the home loan guaranty program. ARMs have become accepted by borrowers in the conventional mortgage market, and FHA has expanded its insurance program to include ARMs. The conventional and FHA markets have demonstrated that ARMs are beneficial because they permit borrowers and lenders to tailor transactions to the needs of borrowers. Borrowers who do not want to pay for the predictability of a fixed rate mortgage can agree to the lower interest rates that lenders can offer when the borrower bears some of the risk of inflation and other economic conditions that generally cause rates to rise.

MBA believes that VA ARMs should be authorized without statutory ceilings or caps on market adjustments. Adjustments should be freely negotiated, just as conventional long-term fixed rate mortgage interest rates are negotiated. At the most, authority could be left with the Administrator of the VA to set caps for ARMs in the home loan program as the program and the veterans it benefits gain experience with ARMs.

Whatever may have been the case previously, ARMs are no longer an untested and unknown quantity. Approximately 53 percent of new conventional mortgages originated in the last quarter of 1983 were ARMs. The percentage continued to rise to 57 percent by the last quarter of 1984 and dropped back to 50 percent in 1985. (Federal Home Loan Bank Board, "Conventional Home Mortgage Rates," February 1986.) Although substantially lower interest rates restored borrower ability to select fixed rate mortgages in 1985 and 1986, ARMs continue to be a significant borrower option in the conventional and FHA markets. Veteran borrowers should also enjoy the option.

VA FORECLOSURE CLAIM PRACTICES (NO-BIDS)

Under the default and foreclosure provisions of the VA home loan guaranty program, the VA has always had the option of either acquiring a foreclosed property and paying the lender the loan amount or leaving the property with the lender and paying only the guaranty amount (a "no-bid"). Although the VA had the authority to exercise the "no-bid" option, prior to August 1984 it did so only in very isolated cases. However, in the "Deficit Reduction Act of 1984" (P.L. 98-369), Congress included a specific formula that significantly altered VA foreclosure claim practices and forced the VA to enter into no-bids. This change represented a drastic departure from practices of the previous 35 years of the VA home loan guaranty program during which the VA, in almost 99 percent of the cases, paid the entire loan amount to the lender and acquired the property.

Impact

Foreclosures of VA-guaranteed home loans have more than doubled in the last five years, with most of the increase concentrated in geographic areas of the country that have been devastated by severe economic setbacks (Exhibit 2). With increasing frequency (from 238 cases in 1982 to 5,236 cases in 1986) (Exhibit 3), the VA has been paying the lender only the guaranty amount and leaving the foreclosed property, which has greatly depreciated in value, with the lender. The no-bid situation has caused lenders to suffer severe losses. With an average net loss per loan of $16,500, industry-wide losses totalled more than $86 million in 1986.

Implementation of Legislative and Administrative Proposals

Currently, the statutory formula that determines whether a VA foreclosed loan results in a no-bid is as follows: If the total indebtedness exceeds the appraised value of the house (net of VA administrative costs equal to 10.5 percent of the loan) by more than the guaranty amount, the VA pays the lender the guaranty amount.

MBA encourages Congress and the VA to take another look at the statutory formula for determining no-bids, and to take into consideration the extraordinary plight of both homeowners and lenders in areas of serious economic distress, with a view toward significantly lowering the number of no-bid cases in such areas.

Although there seems to be no definitive solution to the VA no-bid problem, changes in underwriting, appraisal, and servicing procedures will improve the quality of the VA loans. Legislation enacted in 1986 makes such improvements.

In addition, the formula by which VA determines whether to acquire a property or to pay the guaranty is structured so that delays in the foreclosure process almost inevitably lead to no-bids. When a foreclosure sale is delayed, total indebtedness increases because interest continues to accrue, thereby tipping the scale and creating a no-bid.

VA should issue timely bidding instructions for foreclosure sales so that lender will not have to postpone such sales. In addition, VA sometimes asks lenders to postpone sales and grant forbearance or wait until the loan can be refinanced or sold; this delay again results in a no-bid situation. If lenders are asked by VA to grant forbearance or delay foreclosure sales, VA should assure that the accumulation of additional debt will not result in a no-bid.

Last fall, MBA formed a special VA Subcommittee to review the current no-bid situation and to formulate recommendations to remedy the problem. As a result of the discussions held by the special Subcommittee, MBA has adopted the following recommendations that would help alleviate the no-bid problem.

MBA urges Congressional action that would enable full authority for VA foreclosures to be delegated to lenders. This would involve granting lenders the authority to (1) order the pre-foreclosure appraisal, (2) make the calculation necessary to determine whether the VA should acquire the property or pay the guaranty, and (3) determine the appropriate bidding instructions at the foreclosure sale.

Delays in issuing timely foreclosure bidding instructions, due to inadequate VA staffing, often turn potential VA acquisitions into VA no-bids because of the additional interest accrual during the period of delay. The delegation of foreclosure authority to lenders would reduce these delays, without increasing costs to the federal government. Existing VA staff could be dedicated to monitoring and auditing lender performance to assure integrity of the system.

The statutory formula used to calculate whether a VA foreclosed loan results in a no-bid was enacted in the "Deficit Reduction Act of 1984" (P.L. 98-369). If the difference between the total indebtedness and the net value of the house (appraised value minus VA administrative costs) is more than the guaranty amount, the VA pays the lender the guaranty amount and does not acquire the property. The total indebtedness includes the unpaid principal plus the interest on the loan as of the liquidation sale, or such earlier date following the expiration of a reasonable period for the sale to occur as the Administrator may specify. This provision should be clarified so that the amount of accrued interest due to delays in the foreclosure process does not increase and in some cases turn the foreclosure into a no-bid.

MBA urges several changes that would decrease the number of no-bids that occur solely as a result of interest accrued during the period that a loan is in default.

First, accrual of interest for purposes of the no-bid calculation should cease when the lender is ready, willing, and able to foreclose. However, such interest should be reimbursed by VA as part of the lender's claim if VA acquires the property. Costs of avoidable delays in foreclosing loans would be borne by the VA in cases where the VA is responsible for postponing the expeditious completion of foreclosure.

Second, in cases where a foreclosure is delayed due to circumstances beyond the control of the lender or the VA, such as bankruptcy, lenders should have the option to request that VA cease accruing interest for purposes of the no-bid calculation. In return, lenders would forfeit the right to be reimbursed for such interest if VA acquires the property. Lenders would continue to be responsible for the cost of unavoidable delays due to bankruptcies and lengthy foreclosure statutes. However, by forfeiting a portion of the interest, lenders could avoid acquiring the property.

Third, interest that accrues during a period of forbearance by a lender should not be used in the no-bid calculation, but should be reimbursed by VA as part of the lender's claim if VA acquires the property. VA frequently asks lenders to forbear when a loan goes into default, but the additional interest costs accrued during the forbearance period are not reimbursed by VA. Since VA requests forbearance, VA should pay for the delay if the case turns into a foreclosure. Without such a policy, lenders will be more reluctant to forbear because of the potential of significant losses.

MBA believes that these changes to the loan guaranty program are reasonable and will improve the home loan guaranty program. If lenders are forced to bear increasingly greater amounts of risk and losses, they will be forced, unfortunately, to discontinue originating VA loans.

MBA appreciates the opportunity to present its views and would be happy to provide additional information, if necessary.

EXHIBIT 1

	Maximum VA Guaranty		Median Sales Prices					
			Existing Homes		New Homes 1/		All Homes 2/	
	Amount	% Change From 1974	Price	% Change From 1974	Price	% Change From 1974	Price	% Change From 1974
1974	$17,500	NA	$32,000	NA	$35,900	NA	$32,725	NA
1975	$17,500	0.0	$35,300	10.3	$39,300	9.5	$36,026	10.1
1976	$17,500	0.0	$38,100	19.1	$44,200	23.1	$39,162	19.7
1977	$17,500	0.0	$42,900	34.1	$48,800	35.9	$43,981	34.4
1978	$25,000	42.9	$48,700	52.2	$55,700	55.2	$49,891	52.5
1979	$25,000	42.9	$55,700	74.1	$62,900	75.2	$56,825	73.6
1980	$27,500	57.1	$62,200	94.4	$64,600	79.9	$62,572	91.2
1981	$27,500	57.1	$66,400	107.5	$68,900	91.9	$66,782	104.1
1982	$27,500	57.1	$67,800	111.9	$69,300	93.0	$68,057	108.0
1983	$27,500	57.1	$70,300	119.7	$75,300	109.7	$71,232	117.7
1984	$27,500	57.1	$72,400	126.3	$79,900	122.6	$73,767	125.4
1985	$27,500	57.1	$75,500	135.9	$84,300	134.8	$77,052	135.5
1986	$27,500	57.1	$80,300	150.9	$92,000	156.3	$82,318	151.5

		Price Adjusted VA Guaranty			RATIO: Price Adjusted Guaranty to Actual Guaranty		
	Maximum VA Guaranty	For Existing Homes	For New 1/ Homes	For All 2/ Homes	For Existing Homes	For New 1/ Homes	For All 2/ Homes
1974	$17,500	$17,500	$17,500	$17,500	1.00	1.00	1.00
1975	$17,500	$19,305	$19,157	$19,265	1.10	1.09	1.10
1976	$17,500	$20,836	$21,546	$20,942	1.19	1.23	1.20
1977	$17,500	$23,461	$23,788	$23,519	1.34	1.36	1.34
1978	$25,000	$26,633	$27,152	$26,679	1.07	1.09	1.07
1979	$25,000	$30,461	$30,662	$30,388	1.22	1.23	1.22
1980	$27,500	$34,016	$31,490	$33,461	1.24	1.15	1.22
1981	$27,500	$36,313	$33,586	$35,712	1.32	1.22	1.30
1982	$27,500	$37,078	$33,781	$36,394	1.35	1.23	1.32
1983	$27,500	$38,445	$36,706	$38,092	1.40	1.33	1.39
1984	$27,500	$39,594	$38,948	$39,447	1.44	1.42	1.43
1985	$27,500	$41,289	$41,093	$41,204	1.50	1.49	1.50
1986	$27,500	$43,914	$44,847	$44,020	1.60	1.63	1.60

Sources: Bureau of the Census; National Association of Realtors.

1/New home sales prices and activity for 1986 estimated based on data through November 1986.

2/Weighted average (by sales activity) of median sales prices of new and existing single-family homes sold.

Prepared by the Mortgage Bankers Association of America, Economics Department, February 1987.

EXHIBIT 2

Top 10 States by Number of No-Bids

		FY 1985			FY 1986		
	State	No. of Foreclosures	No. of No-Bids	Pct.	No. of Foreclosures	No. of No-Bids	Pct.
1.	Texas	4,136	258	6	7,338	1,206	16
2.	California	2,775	490	18	2,617	563	22
3.	Ohio	2,156	366	17	1,977	378	19
4.	Colorado	1,459	146	10	1,932	363	19
5.	Illinois	1,685	236	14	2,090	339	16
6.	Oklahoma	734	95	13	1,426	308	22
7.	Indiana	854	128	15	881	182	21
8.	Pennsylvania	876	184	21	825	176	21
9.	Iowa	415	91	22	417	168	40
10.	Washington	1,182	130	11	1,283	165	13

Source: Veterans Administration
Prepared by Mortgage Bankers Association of America, February 1987.

EXHIBIT 3

VA NO-BIDS AND FORECLOSED LOANS

Fiscal Year Ending	Loans Foreclosed	Number of No-Bids	Number of No-Bids As Percentage of Total Foreclosed
1981	12,490	358	2.87
1982	15,427	238	1.54
1983	21,176	689	3.25
1984	23,377	1,496	6.40
1985	27,276	3,055	11.20
1986	34,642	5,236	15.00

Source: Veterans Administration
Prepared by the Mortgage Bankers Association of America, February 1987

THE NON COMMISSIONED OFFICERS ASSOCIATION OF THE UNITED STATES OF AMERICA

"STRENGTH IN UNITY"

STATEMENT OF

Richard W. Johnson, Jr.
Director of Legislative Affairs

Presented to

Committee on Veterans Affairs
U.S. House of Representatives

on

Veterans Administration Budget
FY 1988

February 3, 1987

NATIONAL CAPITAL OFFICE
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VA BUDGET FOR FISCAL YEAR 1988

The VA budget request for 1988 contains few surprises for members of NCOA but it does have some disappointments. Overall, the VA has requested budget authority of nearly $27.6 billion for benefits and operations in 1988, an increase of about $548 million over spending this year. Included in the proposal are increases of $414.1 million in medical care spending, $173.6 million in benefit programs, $37 million in construction and a 3.5 percent increase in veterans disability compensation and dependency and indemnity compensation (DIC) effective December 1. The proposal is an impressive improvement over budget submissions for 1986 and 1987. Nevertheless, there are several proposals to reduce services to veterans and transfer program costs to veterans or other agencies which NCOA finds objectionable.

Cuts are proposed in medical care staffing, inpatient and outpatient visits and the number of beds available to veteran patients. Cuts are proposed in eligibility for burial plot allowances. Cuts are proposed in funding for the home loan guaranty program concurrent with an increase in the loan fee charged to veterans. Essentially, this cut seeks to transfer the cost of the loan guaranty program entirely to veteran participants in the program. And, on the subject of transfers, the proposal seeks to transfer the cost of the New G.I. Bill to the Department of Defense. The proposal announces a "fire sale" of VA loan assets and includes another legislative proposal which NCOA finds particularly disturbing. It suggests eliminating the fixed maximum interest rate on VA guaranteed loans. Many of these ideas have been considered and rejected before. Hopefully, they will not survive this year either. In this statement NCOA will examine each of these issues individually.

However, before proceeding, NCOA wishes to state its general support for the proposals and extend its commendations to the authors. It is certainly not a budget that is "Dead on Arrival".

It is instead a reasonable and thoughtful spending bill which proposes a surprisingly adequate program for veterans care and services in many areas. Unfortunately, this is not the forum to comment on the better aspects of the proposal, but is instead the opportunity to focus on its inadequacies. Accordingly, NCOA is hopeful that its comments will be accepted in that context.

Loan Guaranty

The VA has recommended increasing the current one percent funding fee charged to veterans to 2.5 percent in hopes of offsetting the need for $389.8 million in appropriations. In the absence of legislation, the current and temporary one percent fee would expire on September 30. Additionally, the administration announces its intention to begin liquidation of loan assets at a more aggressive rate and to recommend legislation eliminating the fixed maximum interest rate on guaranteed loans. All three proposals can produce disasterous and expensive effects on veterans.

The administration has offered a plan to transfer the cost of the loan guaranty program to veterans who participate. Essentially, the administration perceives the fees currently charged to veterans as "user fees" and wants to raise those fees to cover the entire cost of the program. Thus fees paid by veterans who satisfactorily fulfill their loan obligations would offset guaranty losses suffered when a less fortunate veteran is unable to meet his loan commitment. Without appropriations the program becomes a veterans helping veterans program wherein the VA acts only as administrator. The fee increase would raise the cost of participation to $1,750 on a $70,000 home an increase of more than $1,000 over the current fee. Such an increase would price many veterans out of the housing market. Additionally, the increase, indeed the entire fee, does nothing to reduce the veterans indebtedness or increase the value of the home. For these reasons, Congress last year rejected a similar proposal to increase the funding fee. Instead, Congress adopted a resolution stating its collective belief that such a fee should not exceed one percent. NCOA urges the Committee to recommend budgeting and appropriations at sufficient levels to allow the current fee to expire, as its sponsors had intended, on September 30, 1987.

Allowing the funding fee to expire is fully justified when considering its cause--a cause which by coincidence relates directly to the sale of loan assets. Funding fees were initiated by Congress to help offset the need for massive appropriations to the VA's Loan Guaranty Revolving Fund (LGRF). The LGRF required appropriations because the income from its assets (interest earnings on loans in its portfolio) no longer exceeded its outlays (payoff on guaranties or aquisitions of properties in default). The deficit in income exists largely because prior presidential administrations discovered that the sale of loan assets produced income which could be used to reduce deficits and at one point ordered the VA to liquidate loans on such short terms that they could only be sold at a loss. This constituted poor management. Such poor management required Congress to authorize nearly $2 billion dollars between 1978 and 1986 to the program which required no additional authorizations between 1958 and 1978. It is estimated that $200 million would have been required to keep the LGRF solvent if portfolio assets had not been liquidated with a fire sale mentality. Now the Administration wants to sell more loan assets, some at substantial discounts below face value, at both the VA and other agencies. Such sales, as in the past, will provide short term and one time relief from budget deficits. But, like real property sales, airport sales, moving paydays and the sale of other assets they offer no long term solutions to spending deficits and exacerbate problems in the future by reducing income. This too, is poor management. Yet veterans are paying for this poor management in the form of funding fees on home loans. That is shameful. Accordingly, NCOA believes the sale of loan assets should be frozen temporarily. A review should be conducted to determine if a portfolio managed under new or modified rules could again support the LGRF alleviating the need for future appropriations before sales are allowed to continue. Such a review might provide long term alternatives to funding fees and loan guaranty appropriations.

Finally, the VA has announced its intention to recommend legislation which will eliminate the fixed maximum interest rate on guaranteed loans. While this proposal has no fiscal impact on the VA it can have a devastating impact on home buyers. The current maximum rate is established and adjusted under law by the Administrator to reflect current market trends. It is generally kept at the low end of the market scale for mortgage lending to assure somewhat universal treatment of veterans in home purchases. Taken together with the "point" limit it precludes situations where veterans may pay vastly different prices to finance homes of relatively equal value. This fixed rate also serves the nation as something of a benchmark with which commercial lending institutions must compete. In other words it keeps the mortgage lending rates competitively low--not artificially low as many allege. It is unlikely that veterans will be able to "negotiate" rates as the VA states. Instead, rates will continue to be set by individual institutions, not really subject to the kind of give and take the word negotiate implies. Furthermore, with no rate ceiling, or competitive mark, lending institutions will be free to set their own rules. For example, rates may be fixed at one level for 80 percent loans, at another higher level for 95 percent loans and a still higher level for no money down loans, a mainstay advantage in the VA loan guaranty program. Additionally, while the point limit may remain in law, there does not appear to be any method of preventing point shifting from the seller to the veteran by increasing the loan interest rate. NCOA firmly believes elimination of the fixed maximum rate would be extremely detrimental to veterans.

Compensation

The major provision included in the budget with regard to compensation programs for veterans and their survivor is the Administration's proposal for a 3.5 percent cost-of-living increase effective December 1. The budget proposal does not address any other significant changes in compensation programs.

NCOA fully supports the proposed cost-of-living increase and urges committee endorsement for supplemental funding to fund the compensation increase which became effective on December 1, 1986. Concurrently, NCOA urges the committee to review the adequacy of the Dependency and Indemnity (DIC) program. The association still believes the program should be restructured to more reasonably meet the financial obligations of government and the needs of survivors.

NCOA would also like to take this opportunity to endorse Representative Mike Bilirakis' bill and similar legislation allowing concurrent receipt of nondisability military retired pay and veterans' disability compensation. Under current law military retirees who are also disabled enjoy only the tax advantage of receiving disability payments while other veterans receive the full value of such compensation since only they are required to forfeit income from another source to receive disability payments. No other veteran, including federally employed or retired veterans, are required to forfeit pay or retired benefits to receive disability compensation. Thus, NCOA can see no reason to continue this unique discrimination against military retirees. NCOA extends its appreciation and commendation to Mr. Bilirakis on this issue and urges the committee to fund the bill this year.

Readjustment Benefits

The budget recommendation for readjustment programs in 1988 reflects the declining number of veterans eligible for training under the Vietnam era G.I. Bill and diminishing obligations in this area. Thus overall obligations in this account are expected to decline. Additionally, the VA has asked that funding for the New G.I. Bill be transferred to the Defense Department as an appropriations function of that agency. Unfortunately the proposal does not address other needed improvements in readjustment benefits.

NCOA does not support the transfer of funding obligations for the New G.I. Bill from the VA to DoD nor does the association subscribe to the underlying proposition that the New G.I. Bill is merely a recruiting program. As with previous G.I. Bills the stated purpose of the New G.I. Bill is "to provide a new educational assistance program to assist in the readjustment of members of the armed forces to civilian life after their separation from military service." And, like the Vietnam Era G.I. Bill and the Veterans Educational Assistance Program, the secondary concerns of encouraging young men and women to serve in the armed forces are listed among its purposes. Yet this program remains a veterans benefit, contained within that portion of law which describes veterans programs, administered by the Veterans Administration, created and reviewed by the Veterans Affairs committees under their jurisdiction and oversight authority. It is to NCOA clearly a veterans benefit producing a necessary and desired side effect of aiding armed forces recruiting and retention.

Transferring funding responsibility for this program would only encourage the Defense Department to manipulate the program to the disadvantage of veterans. During hearings on the program in its formulative stage, DoD consistently referred to the program as a "force management tool" and recommended many ways of using education benefits to selectively recruit and retain members of the armed forces. DoD even suggested the use of a trigger mechanism to allow service secretaries the opportunity to turn the G.I. Bill on and off to address force management objectives. Fortunately Congress recognized that a true G.I. Bill was too inflexible in its objectives to accomplish these force management requirements as effectively as bonuses, training assignments, etc. Mindful of recruiting needs, Congress masterfully crafted a program which encouraged military service but primarily fulfilled the education and readjustment need of veterans. Yet, last year, DoD recommended termination of the program before the end of the test period and DoD has already suggested a cut in program benefits this year. NCOA does not believe DoD would sustain the program if tasked with its funding. Accordingly, NCOA opposes the transfer.

In the budget proposal the VA failed to address any improvements in the New G.I. Bill or other existing readjustment programs. For example, education benefits under the Vietnam Era G.I. Bill and the vocational rehabilitation program have not been increased since October 1, 1984. At that time, Congress provided an increase of ten percent over rates set in 1981. As a result, the value of these important readjustment and rehabilitation benefits have diminished substantially. Since 1981 the cost of a 4-year education at a public institution has risen 56 percent according to the Department of Education while VA payments have risen only 10 percent. Concurrently, Congress has appropriated billions of dollars in non-veteran education programs creating a G.I. Bill without the G.I. NCOA urges the committee to include an increase in these veterans' programs in its budget request.

Finally, in this category, NCOA encourages the committee to include funding in its budget request to make necessary improvements in the New G.I. Bill. NCOA continues to support elimination of the enrollment fee for users of the New G.I. Bill but asks, at least, that funding be provided to allow refunds to individuals who do not use their benefits, who must disenroll for financial reasons or to the survivors of those who die prior to enrollment. NCOA also recommends funding to make eligible and pay benefits under the new program to Vietnam era veterans who must retire from military service prior to June 30, 1988. Federal law and military regulations will prevent many career servicemembers from completing the required three years of service to become eligible for benefits under the new program, but they no longer have the time to fully use their old G.I. Bill benefits before the expiration of that program. In the interest of equity, such a change should be made.

Burial Benefits

At one point in time every veteran could count on collecting one benefit of service in the Armed Forces-- a burial benefit paid by the VA and a flag to cover the casket in honor of service. Sometimes these benefits make a decent burial better, too often they made a decent burial possible. Now only disabled, and in some cases, indigent veterans are eligible for burial benefits. The last vestages of universal reward for veterans manifests today in the plot allowance and the burial flag. Now the VA seeks to eliminate the plot allowance for non-disabled veterans who are not interred in national cemeteries. NCOA urges the committee to reject this proposal and sustain the $31.3 million appropriation necessary to provide this benefit. NCOA might be more inclined to support this legislation if every veterans had reasonable access to a national cemetery, but until that is the case no consideration can be given to this proposal.

Additionally, NCOA is pleased to recommend that funding be included in this year's budget and legislation be enacted to allow the VA to provide burial flags to the members of the National Guard and Reserves. These citizen soldiers, sailors, airmen, and Marines contribute significantly to the National Security and defense interests of the United States. This token reward for such service would be deeply appreciated.

Medical Care

Notwithstanding a proposed $414.1 million increase in spending for medical care in 1988, NCOA senses an inadequacy in the proposal. Immediately obvious is a realization that the loss of 3,810 full-time employees, two percent of the medical care workforce, will adversely affect the availability or quality of medical care to veterans. Furthermore, NCOA does not understand how the VA can project a decrease of 10,000 inpatients and 113,000 out-patient visits in view of the needs of an aging veterans population. This, in fact, is probably the greatest omission in the budget. For yet another year the Veterans Administration has largely ignored the need to develop an implement an aggressive nursing and geriatric care program for the aging veteran population. The proposed cut of $400 thousand from state home funding grants is a clear indication that the Administration lacks the far sighted policy needed to adequately address this issue.

The one percent efficiency increase the agency announces will save money and staffing is a laudible goal. Yet such savings should be used to build the system to meet its current and anticipated needs, not to meet the budgeting objectives of OMB. For example, the VA has pending proposed regulations to eliminate beneficiary travel payments for almost all veterans except those who require a special mode of transportation. The proposal has caused tremendous turmoil among veterans and works in direct contravention to recently announced outreach effort to homeless veterans. It is even more inconsistent with the VA's current emphasis on providing medical care only to those veterans who cannot afford alternate sources of care. Yet rather than seek a reprograming of $75 million in medical care funds, only part of which would be necessary to fund beneficiary travel, the VA has requested a recision. Rather than redirect part of its one percent efficiency savings, the VA requests a reduced budget.

Consistent throughout the budget request is a lack of future. There is no acknowledgement of the national emergency role of VA medical facilities; there is no obvious planning for the treatment of aging veterans; there is no anticipation of any out year needs. The budget is in fact as short-sighted as the sale of assets suggested to offset the funding needs of other programs.

The President's budget message clearly stated the Administration's objective to reduce real spending for veterans medical care by $100 million in the coming fiscal year. This is obviously a regressive move on the part of the Administration which should not be sustained by Congress. NCOA urges the committee to increase medical care spending to at least a current services level or, more desirably, to a level which allows real growth in the program.

Staffing

A substantial portion of savings recommended in the VA budget is attributed to cuts in full-time equivalent employees (FTEE). However, these cuts are largely undefined in the budget. The VA simply states an anticipated one percent efficiency reduction will save 1,900+ FTEE in the Department of Medicine and Surgery (DM&S). A further cut based on a reduction in the level of current services to veterans is expected to rob DM&S of 3,800+ FTEE. In the Department of Veterans Benefits (DVB) a 250+ FTEE loss is loosely attributed to the decline in application for services from Vietnam era veterans. Yet, nowhere in the budget are these cuts defined by job category or occupation. Who are these people? Are they doctors, nurses, physical therapists, food service technicians? Does their loss reduce staffing ratios or prevent good patient care? Will the loss of DVB personnel affect the new outreach efforts to homeless veterans or a growing need for service to veterans applying for benefits under the New

G.I. Bill?

These question create still more questions about staffing levels. NCOA does not know how many doctors, nurses and physical therapists are required to adequately staff an 84,000 bed medical care system but neither is the association convinced that the VA knows. NCOA does know that it takes four months or more to have the results of disability physicals transcribed and sent from medical centers to regional offices in some areas. NCOA knows that other requests for services languish for considerably longer periods. Under such circumstances staffing cuts seem an unlikely solution to budgetary savings. Instead NCOA recommends that some effort be devoted to assessing the personal needs of the agency to determine adequate staffing in a manner inconsistent with its mission and size. Until such time as real staffing needs are known and proposed cuts in personnel are defined, NCOA cannot support any FTEE reduction.

Conclusion

At the outset NCOA stated its general support for the proposed budget and we reiterate that position now. However, NCOA also supports the improvements in loan guaranty benefits, readjustment benefits, burial benefits, compensation and medical care recommended herein.

We also note for the committee that a disturbing trend of cost avoidance seems to be building in VA budget requests. As noted earlier, the VA wants to transfer the cost of the New G.I. Bill to DoD and has deleted research funding in favor of DoD and the Department of Health and Human Services funding for programs. The VA seeks to transfer the cost of the loan guaranty program to its veteran participants and concurrently wants to allow the investment community to gratuitously profit from loan sales and elimination of fixed maximum interest rates. In past years, the VA has sought, successfully, to divest itself of responsibility for health care of a large segment of the veterans community by transferring that cost to veterans who will now pay higher insurance premiums. And, the VA has ignored the need to keep other major programs current to the needs of veterans and their survivors as is the case in education and rehabilitation programs.

Essentially, the VA seems to be divorcing itself, little by little, from the constituency it is designed to support. NCOA can only wonder if this is not building to a point when someday all servicemembers will be contributing from their monthly pay to support veterans benefits or if there will be any benefits for those who serve their nation. This trend must stop before it becomes impossible to rebuild the agency to the level of support necessary for veterans' programs. Anti-war activists of the sixtys used to ask, "What would happen if we had a war and nobody came?" As services to veterans continue to erode, they may have their answer.

-end-

Congressman Thomas J. Ridge
Opening Remarks
House Veterans Affairs Committee
February 4, 1987

Thank you, Mr. Chairman. Regrettably I was unable to attend yesterday's hearing, but I understand that my colleagues on both sides of the dias did an excellent job in responding to some of the concerns about the Administration's budget proposals.

I don't want to start this new Congress in a confrontational manner with the VA. Indeed, I sincerely hope that this committee and the VA will carry on -- as it has in the past -- in the spirit of cooperation and compromise. However, after reviewing the Administration's budget proposal for FY '88, I feel compelled to speak out in strong opposition to some of the ideas and propositions put forth in this budget document.

Although today's hearing is intended to focus on the health care budget, if I may, I would like to make one brief comment in response to the Administration proposal to raise the home loan origination fee from one to two-and-a-half percent. Frankly, I am appalled that the Administration has ignored strong and unanimous opposition in the past from Congress and the veterans community to ANY increase in the home loan fee. Consequently, I have introduced a resolution, once again reaffirming Congress' opposition to the proposed increase in the fee. I'm grateful for the support of the good Chairman, the distinguished Mr. Solomon, and over 35 of my colleagues both in and out of this committee. I encourage all of you to join me in sending a strong and clear message to the administration that any proposal to raise the home loan fee will be flatly rejected.

To turn now to the portion of the budget for medical care, I first want to applaud the provision to reactivate the Health Professional Scholarship Program. Facing critical personnel shortages in nearly all VA health care facilities, this proposal is crucial if we are to meet the growing demands of a rapidly aging veteran population.

Unfortunately, my applause stops there. Although many of the proposals in the health care budget disturb me, I am most disturbed by the proposed $75 million rescission of already appropriated FY87 funding. Under the guise of deficit-reduction, this proposal attempts to eliminate funding that would otherise be used for the care of higher income, non-service connected veterans. In reality, this rescission would result in a reduction of nearly 16,000 inpatients and over 212,000 outpatients served by the VA, according to analyses by Chairman Montgomery.

I am especially incensed by the rescission proposal, however, because of the message it sends to veterans with non-service-connected medical needs. In the last Congress, we enacted landmark legislation implementing a means test for veterans seeking health care. For the first time, we said to veterans who have non-service connected disabilities and whose incomes exceeded certain specified amounts, you may receive hospital or nursing home care on a space-available basis, but only if you agree to make a co-payment for that service.

I've made no secret of my opposition to the means test. But I also respect and understand why the majority of my colleagues supported it in light of few alternatives to budget-cutting requirements imposed on this committee. This rescission request, however, goes well beyond congressional intent of legislation implementing the means test. Indeed, as I see it, the President's request is designed to reduce the size of the VA's health care system through the elimination of funding for Category C veterans.

I'm concerned about the message this proposal is sending to veterans of today as well as veterans of tomorrow. I suspect our armed forces recruiters are working overtime these days attempting to convince prospective recruits that the benefits we offer soldiers today will be there tomorrow.

This shouldn't be the case, Mr. Chairman. And in response to these concerns, I introduced another resolution expressing Congress' disapproval of the $75 million rescission and declaring that Congress will not approve such a proposal. This resolution has also received the support of the Chairman and Mr. Solomon, and many members of this committee. Our nation's veterans have fought their battles on the battleground. They certainly don't need another one in Washington.

METHODOLOGIC, STATISTICAL, OPERATIONAL, AND MANAGEMENT PROBLEMS ASSOCIATED WITH THE RESOURCE ALLOCATION MODEL(RAM)

Although concensus appears to exist that some form of structured mathmatical model should exist to guide resource allocation in the Veterans Administration Medical Care System; the current model is so methodologically flawed that the continued use in the present form is not rational. Policy decisions based on the model have exacerbated the problem to a point where the process itself has little credibility.

The RAM does not measure productivity and the costing methodology used commits the Ecological Fallacy and therefore renders the RAM invalid.

In an attempt to characterize costs of treating patients in both the inpatient and outpatient setting where DRG's and Patient Stops represent the cost units the model apportions the costs by disaggregating cost information collected at the service level. This dissaggregation process violates a central principle which states that information collected at a group level cannot be dissaggregated to reliably describe individual components of the group. This principle has been known by epidemiologists for years and violation of it is known as commiting the Ecological Fallacy. Failure to take note of this principle has rendered a number of epidemiologic studies invalid.[1,2,3] Because this principle has been violated by the RAM the cost characterizations, comparisons, and correlations of the inpatient and outpatient products (DRG's and Stops) are invalid.

The Method of Computing Direct Costs of DRG's Does Not Characterize Actual Resource Use.

The Direct Cost of a DRG is represented by the following equation.

Cost of DRG = Length of Stay (LOS) x (Hotel cost* /day + Ancillary Service cost / day + Physician cost / day)

The VA calculates the cost of a DRG as :

LOS x Per Diem cost + cost of an Operative Procedure or Cardiac Catheterization (if applicable)

Major problems are inherent in the VA method for the following reasons:

1. Use of Per Diem cost in calculating resource use.

Per Diem cost = cost distributed to clinical service (RCS 10-0141)/ Total Patient Days of care given by the service

Therefore, this cost represents an average cost for a day of care and includes the average cost of physicians, ancillary services , hotel , and nursing costs.**Average Per Diem costs do not represent the actual consumption of resources by a DRG.**

For instance we are asked to believe that DRG 105, Cardiac Valve Procedure with pump w/o Cardiac Cath has the same value as DRG 113, Amputation for Circ System Disorders except upper (156 vs 158 wwu),

2. The Calculation of Operative Cost.

Operative cost is taken from the Medicare data files which display the percentage DRG charges which emanate from the operating room and anesthetic usage. It is known that there is compression in Medicare DRG's whereby costly DRG's are undervalued and inexpensive DRG's are overvalued.[4] This compression is made more severe by the VA method of valuation. HHS calculates the value of a DRG as follows:

DRG cost = LOS x Hotel cost + Ancillary Service cost

Although HHS can find Ancillary Services use from the patient bill submitted, the problem is that HHS data is charge data and has to be adjusted to cost using the hospital specific cost reports. This method while flawed , because adjusting charges to cost by the comparison of overall hospital costs vs revenue does not accurately cost the individual products used in diagnosis and treatment ; it nevertheless tracks actual resource use. VA DRG values are more compressed than those of Medicare. This raises serious questions about the computed cost of operative procedures.

Outpatient costing methodology is seriously flawed

The Ecological Fallacy is commited in outpatient costing. Cost information collected at a higher level is disaggregated to characterize individual encounters. Furthermore , the method by which cost information is collected into the 13 categories in outpatient care creates the illusion of accuracy. The method requires an individual to estimate the amount of time spent in various outpatient activities. This method becomes increasingly inaccurate in proportion to the number of activities in which a person is involved.

The problem with thresholds-In 4 of 5 outpatient visit categories entry into the group is based on achieving a threshold number of visits after which credit for a given quantity of dollars is received. This method therefore treats costs as a threshold phenomenon and not as a function of specific unit activity.

The problem of unbelievable RAM outputs -Inspection of the RAM outputs yield the following examples which destroy the credibility of the model.

Hospital #	Reported Expenditure $	Earnings $	Exp/wwu
523	6,484,891	13,208,328	1.99
688	10,052,707	19,186,227	2.12
679	1,962,320	3,644,606	2.18
542	2,193,380	4,081,547	2.18
578	12,016,113	22,065,129	2.21

Systems average cost/ outpatient wwu = $ 4.06 . We are asked to trust the integrity of a model and the subsequent allocation process which tells us that there are VAMC's producing outpatient care at a cost 100% more efficiently than the mean. This is patently absurd. The reasons why this may be true are numerous and include erronous distribution of expenses on the RCS 10-0141, workloads generated from special programs whose costs are not included, gaming of the system (meeting thresholds), faulty concepts incorporated into the model concerning the nature of outpatient visits, workload generated by housestaff, and workload generated by contributed labor.

Costing methodology is so generally flawed that it cannot rationally be used to measure productivity.

The objective of the RAM is to determine differences in production efficiency (productivity) between defined activities in the various hospitals. To do this an average cost is computed for the production product (DRG, Outpatient Stop, RUG). Those who have costs above average are deemed less efficient,those below more efficient.

The general equation for productivity is as follows:

P = Outputs / Supply + Labor + Capital + Overhead costs x100

In the VA where outputs are DRG's, outpatient stops, and RUG's the RAM methodology does not recognize all parts of the production equation. It only recognizes reported cash costs. Capital costs treated as sunk costs and overhead costs (which are treated as pass throughs) are not acknowledged.

The practical consequence of this is that hospitals which do not have in house activities to provide certain services and who must buy these services are automatically dicriminated against by the model. The following examples demonstrate this point.

Radiation therapy,CT Scans, MRI Studies

When these therapies and studies must be purchased outside of the VA the price paid the vendor covers labor, supply, overhead, capital replacement costs and a small margin for profit. When the VA provides the service cash costs reported on the RCS 10-0141 cover only labor and supplies. Overhead and Capital replacement are not reported. In the cases cited capital costs, particularly when calculated at replacement value represent a significant fraction of the total cost. Therefore, the in house activity wins,by receiving the targeted reimbursement for the special procedure and in addition the overhead as a pass through.. The purchased activity loses. The differential loss may approach 80%.

The Cost Distribution Report (RCS 10-0141) creates an illusion of accuracy- A complete discussion of the defects in this report is not the purpose of this paper. Suffice it to say that in a system where labor cost is between 60-65% of all costs, apportionment of these costs become a critical issue if productivity is to be a benchmark for resource allocation. Labor time is distributed based on estimates by individuals on how much time they spend on specified activities. The model uses the cost distribution report to determine costs of those cost objects used to determine productivity. The game is such that the distribution of costs to pass throughs has been refined to such a high art that the process is without credibility. This has been possible because the model, among other things, has been incomplete. A true costing system would prevent this. In the last two to three years numerous additions have been made to the chart of accounts (increasing the number of pigeon holes) and this has created an illusion of accuracy.

Operational / Policy Issues

Winners & losers-The policy position has been to consider mean performance a desirable goal. (The wisdom of this on philosophic grounds bears separate discussion) .Based on this VAMC's whose performance is above mean cost are penalized by withdrawl of resources and those with lesser costs are rewarded with the addition of dollars. Caps on dollar movements were put in place to moderate resource movement.

Since it has been shown that the model is badly flawed such a policy position is untenable. Averages should never be used as a basis for dollar movement. Instead outliers should be identified as expressed by percent deviation from some modeled point. Once identified, the outlier should be investigated by a management team to determine whether or not resources should be withdrawn or added. The model should be far better than the one currently in use.

The Cart vs the Horse- The model attempts to define current practice behaviors and express them in dollar terms. Once the outputs are known, the model which now takes on the mantle of desirable medical practice causes the movement of money to make sure behavior matches the model. It would seem that the steps should be reversed. At the very least the model output should be put to the test of whether or not its implementation promotes desirable practice behaviors.

As an example one Nursing Home Care Unit in the system loses >50% of its resource because it does not fit into the RUG classification scheme. Despite requests by the facility for an appropriate group to make a practice judgment , resources were withdrawn in two successive years without such a review. The particular unit operates as a rehabilitation NHCU with turnover rates ten times the VA average. The RUG model was designed to characterize costs for patients who reside in typically low turnover Nursing Homes.[5,6] It made no provision for turnover or rehabilitation. **The policy question is clear. Do we wish to promote rehabilitation or not?**

Absence of a management function- Gaming of the system has been rampant since its inception. Movement of money from one category to another on the cost distribution report has reached a high level of proficiency. Anecdotes of creative interservice transfer policies, manipulation to achieve thresholds in the outpatient model, creative counting of clinic stops pervade the grapevine; yet there is no evidence that concerted management analysis and action have been put in place to control the process. A fascination with numbers seems to have paralyzed reason in the system.

Problems with consistent policy-The dollar movements between hospitals were muted by the imposition of a progressive cap which was designed to bring full dollar movement in the 5th year of the use of the model. Conceptually this was managerially sound. The problem has been that winning hospitals have not realized the fruits of their presumed efficiency and the losing hospitals have lost consistently. The money generated from the losers has been used for other purposes. In FY 86 a great proportion of the money was diverted to activations. These activations monies were given regardless of the win/loss status of the receiving hospitals. In FY 87 money was taken off the "top" to fund special initiatives. In addition the model changed creating a different set of winners and losers. One day the game was baseball the next day hockey. In addition allocation of non-recurring so-called drop monies have been distributed primarily to winners. The effects of this single policy decision are disastrous and this should be patently obvious on the surface when one considers how these funds are used at the hospitals. It becomes clear as detailed in an analysis by Mr. John Powers fiscal officer for Region 1 (presented below) that once the losing track is entered there is no way to climb out of the hole.

Once in the hole you cannot climb out - Mr. Powers argument is as follows: " The RAM model adjusts facilities recurring dollars on workload which occurred two years prior. This lag between workload generation and the application of the RAM adjustment throws the facility into a perpetual sine curve and makes it virtually impossible for the facility to re-establish parity with the system once it has fallen out. The sine curve is driven by the two year lag between workload and the adjustment.The two year lag allows the facility to operate for two years at a level which is disparate from the national average. This results in two identical RAM adjustments. When the first RAM adjustment takes effect it brings the facility back in line with the system average [this assumes no cap of course] , however the following year the the second RAM adjustment over compensates and sends the facility farther away from system average. Now a new pair of RAM adjustments is triggered and the cycle becomes self perpetuating. The curve can be ended by having RAM adjustments take effect the year after the workload which generated the adjustment."

Mr. Powers' argument is contingent on the assumption that the overall productivity of the system remains constant. One can easily see that attempts to improve efficiency might well backfire. For instance if certain activities are transferred from inpatient to outpatient and if the model does not properly value the outpatient procedure,visit, etc. then the facility can dig a deeper hole. Furthermore, the constant requirement to get rid of people or to hire them based on the allocation for the year creates an untenable managerial situation. It totally destabilizes the patient care process.

SUMMARY & RECOMMENDATIONS

Whether we like to admit it or not we have a system which in the short term has a very large fixed cost component. Personnel policies are designed to preclude rapid adjustments. A political climate exists which precludes vertical cutting. One must therefore design an approach which allows changes of direction over an acceptable time span. This time span is probably 3-5 years.

If a model is to be used it must have integrity. It must describe productivity in financial terms. This requires that true costs must be known at the product level (patient encounter); further all relevant costs must be recognized. Policy decisions are required to define outliers in productivity. These outliers must be subjected to rigorous management analysis. If after analysis, changes are required a specific 3 to 5 year plan must be laid down for the facility to meet the assigned goals.

In summary:

It is not managerially sound to make major changes in budget allocation based on a deviation from an average which comes from a grossly imperfect model.

It is not managerially reasonable to use a cost distribution system for determining resource allocation which is subject to the gaming clearly demonstrated in the system. Rather a true costing system is required.

It is not sound policy to add or subtract money from a budget based on modeling considerations without detailed management analysis.

It is not reasonable to represent costs of services or products as costs when the costs have been derived by committing the Ecological Fallacy.

It is clear that the current RAM model must be drastically altered in its conceptual dersign and in the policy positions which determine how the model is used.

Characteristics required for an adequate model.

1. Taxonomy used by the model must describe the desired medical care process so that the valuation accurately represents the cost of the process.

2. All relevant costs must be represented in the model.

3. Dissaggregation of costs to describe component costs must not be done.

4. Must allow flexibility to accept new practice patterns.

5. Individual components must be directly costed and costing methodologies developed to permit this.

6. Must be developed with wide participation of those affected.

Requirements of policy

1. Must be consistent from year to year with changes made only after reasonable system wide discussion and notification.

2. Must be flexible

3. Must use modeled outputs only for rough guidance at the micro level of hospital allocation. Outlier identification is the major purpose of the model at the micro level.

4. Managerial expertise must be developed for the purpose of analysis of outliers.

5. Must develop a means of communicating ways to enhance efficiency system wide.

Interim suggestions:

1. Discontinue RAM allocations until a new and tested model can be put in place.

2. Return all hospitals to annualized FY 85 base + activations & special programs.

3. Develop Regional allocations: Entrust RD's to negotiate individual hospital allocations and require hard and defensible justification if the allocations deviate significantly from the FY 85 annualized base.

4. Develop mechanism for defining desired practice and design model to fund the practice.

References:

1. Kleinbaum, Kupper, & Morgenstern, Epidemiologic Research,Belmont Ca., Wadsworth, Inc.p78-81

2. Robinson,Ecological Correlations and the Behavior of Individuals, Am.Soc.Review, v15,351-357,1950.
3. Selvin, Durkheims Suicide and Problems of Empirical Research, Am. J. of Sociol.,v63,607-619,1958.
4. Lave,J.R.,Is Compression Occurring in DRG Prices?Inquiry 221985; p 142-147.
5. Fries,B.E.,Cooney,J.R., Resource Utilization Groups, A patient Classification for Long-Term Care, Medical Care 1985 v23,#2,p110-122.
6. Fries,B.E.,Cooney,J.R.,Validation and Use of Resource Utilization Groups as a Case-Mix Measure for Long term Care, Medical Care 1985 v23 #2,p123-132.

Howard H. Green MD 1/3/87

Methodologic and Statistical Problems with the Resource Allocation Model

A concensus appears to exist that some form of objective indicator, such as a mathmatical model is desirable to guide resource allocation for The Veterans Administration Department of Medicine and Surgery. It would appear several central principles have been violated , however, in the structure and application of the current resource allocation model(RAM).

In the structure of the RAM the major principle violated is known by epidemiologists as the Ecological Fallacy.[1,2,3] This states that one cannot characterize individual components of the whole from information collected about the whole. Specific to VA, costs collected at the Service level cannot be accurately disaggregated to characterize components (patient episodes of care) which make up the costs of that Service . Patient length of stay (LOS) times average bed day costs (derived from the total clinical service cost divided by total bed days) does not reflect the actual costs of individual DRG's. The costs of the component resources used to create the DRG must be tracked to acquire an accurate cost for the DRG.

In reviewing the background of use of DRG's, we find that DRG's (Diagnostic Related Groups) were originally developed for utilization review. In this DRG's have proven very useful. HHS then utilized DRG's for Medicare pricing of episodes of care. In Medicare, DRG's are priced according to the total "costs" (cost adjusted charges) of the individual resources used per patient episode. These resources are tracked from the patient's hospital bill. The individual costs used in this method are not highly accurate, due to the cost shifting which characterizes hospital charges. But since the component resources used in an episode of care are tracked and a more or less realistic value is attached to each, the Medicare use of DRG's for patient episode pricing has some realistic predictive value.The limitation is that while DRG's are relatively homogenous with regard to LOS, they are not so with respect to resource use.

The Department of Medicine and Surgery computes a DRG cost in the following manner. Each patient episode of care is assigned to a DRG category. The cost of the DRG is defined as the patient specific length of stay (LOS) X the Service specific per diem cost from the Service on which the patient is being treated. The cost of a DRG for the hospital is calculated as the total dollars allocated by this method to that DRG divided by the total episodes of care attributed to the DRG. Where an operative procedure is performed the cost of the procedure is added to the cost of the DRG.

The Veterans Administration methodology does not and cannot recognize the differences in cost between DRG's in terms of actual resource use.

Structurally there are also other major fallacies in the VA Resource Allocation Model , in particular with assumptions about the cost behaviors of transfers between services and with the Resource utilization group (RUG) model for long term care. Similar problems exist with policy decisions dealing with one- day stays and with cost distribution methodologies within the hospital. A detailed discussion of these is not germane in light of more serious issues detailed above , and also below.

Since the DRG value is inherently faulted further use of these values to determine production efficiency is not logical.

In the methodology of applying the RAM to budget individual hospitals, several statistical principles are also violated. If one were able to assume that the VA weighting method for DRG's were such that the odds of misweighting were randomly distributed (which one cannot) then a very large number of discharges would be required before equality of reimbursement is achieved between individual hospitals. The small numbers of discharges actually seen annually at hospitals preclude an equitable distribution. For instance ,when the RAM is keyed to average cost then at the number of discharges seen at the hospital level, hospitals falling within 10 to 20 percent of mean may not be significantly different . Statistical significance may be achieved between Regions because of the number of hospital discharges. Were this true then the allocations could be made fairly at the Regional level.

It is claimed in defense of the method that when one plots the total hospital cost for producing the DRG's in each of the VA hospitals against the weighted work units produced by each hospital that variance is explained at a high level. One would not expect otherwise since one variable depends on the other.

In Summary:

Models are useful for understanding systems. As a matter of principle allocation dictated by the absolute numbers derived from such models is poor policy.The 172 VAMC system has far more variables than can be adequately handled at the microlevel by a model.In addition, accurate data,ie actual costs of resources used per case, must be used for such a model to have relevance.

(1)It is suggested that a moratorium be placed on the operational allocation of resources according to the RAM .(2)Action should be taken,as a result of an analysis by a model ,only when an institution varies from the mean by a certain percent and when it is decided by policy that the behavior resulting in the major deviation needs to be changed.(3) Further, it is suggested that it is preferable to determine what practice behaviors the VA wishes to have first and then to design models to appropriately fund such behaviors (4).Subsequent selection and application of models should only result from wide participation of those who will be operationally affected.

References:

1. Kleinbaum,Kupper,&Morgenstern,Epidemiologic Research,Belmont Ca.,Wadsworth,Inc.p 78-81.
2 .Robinson,Ecological Correlations and the Behavior of Individuals, Am.Soc.Review, v15,351-357,1950.
3. Selvin,Durkheims Suicide and Problems of Empirical Research,Am. J.of Sociol.,v63,607-619,1958.

By
Howard H. Green MD
November 1986

Dartmouth Medical School
DEPARTMENT OF COMMUNITY AND FAMILY MEDICINE
Hanover, New Hampshire 03756

November 24, 1986

Howard H. Green, M.D.
Chief of Staff
Veterans Administration Hospital
White River Junction, VT 05001

Dear Howard:

Enclosed are references pertaining to "ecological fallacy" :

1) Kleinbaum DG, Kupper LL, and Morgenstern H. 1982. Epidemiologic Research. Belmont, California: Wadsworth, Inc., pp. 78-81.

2) Robinson WS. 1950. Ecological correlations and the behavior of individuals. American Sociological Review 15: 351-357.

3) Selvin HC. 1958. Durkheim's suicide and problems of empirical research. American Journal of Sociology 63: 607-619.

The latter two papers are the ones I see most often cited.

By the way, I am currently collaborating with Bob Fetter at Yale on the Health Care Financing Administration project to refine the DRG definitions. You referred to this project in our phone conversation today, so let me know if you want more information on it.

I will be with my family in Connecticut from November 26 through November 30. Dan will be here on Wednesday the 26th, and he has all the material I have already sent you. We are both interested in receiving copies of your position paper on this topic.

Sincerely,

Jean L. Freeman, Ph.D.
Assistant Professor

Dartmouth Medical School
DEPARTMENT OF COMMUNITY AND FAMILY MEDICINE
Hanover, New Hampshire 03756

November 24, 1986

Howard H. Green, M.D.
Chief of Staff
Veterans Administration Hospital
White River Junction, VT 05001

Dear Howard:

During our recent conversation on the limitations of the VA allocation system, you expressed concern that the VA weights did not accurately reflect the costs of treating patients in different DRGs. Lave makes the same arguement regarding the Medicare weights in the attached article entitled "Is Compression Occurring in DRG Prices?" I thought this material might be useful to support your position, since many of the problems Lave cites with the Medicare weights are inherent (and possibly more severe) in the VA weighting system.

I apologize for not getting back to you sooner with this material. Due to a death in the family, I was out of town all last week.

Sincerely,

Jean L. Freeman, Ph.D.
Assistant Professor

Judith R. Lave

Is Compression Occurring in DRG Prices?

Many analysts believe that the prices of truly high cost DRGs are set low relative to their actual costs whereas the prices of truly low cost DRGs are set high relative to their costs. To test whether such "compression" is occurring, I examined the algorithm that the Health Care Financing Administration used to create its DRG pricing structure. I then compared the HCFA algorithm with the more refined weighting systems used by Maryland and New Jersey to create their DRG payment systems. I found that compression is indeed occurring in the Medicare system relative to both the New Jersey and the Maryland systems. This compression will assume special urgency for some hospitals when the standardized national DRG payment system is phased in or if stringent limits are placed on the overall rate of increase in DRGs.

Under Medicare's Prospective Payment System (PPS), each Medicare hospital inpatient is classified into one of 468 diagnosis related groups (DRGs) for which the hospital receives a fixed amount for treatment. Although the *absolute* amount that a hospital receives for a given DRG now varies across hospitals, the *relative* payments across DRGs are the same for all hospitals. Thus, hospital A may receive more than hospital B for a craniotomy case, but both hospitals receive 2.9 times more for a craniotomy than for a prostatectomy.

The structure of the DRG payments is important because hospitals increasingly will scrutinize the relationship between the price they receive and their cost of treating each DRG to determine what types of patients they may want to emphasize and perhaps how to treat them. Many analysts believe that the current set of Medicare relative prices may be compressed; that is, the prices of the truly high cost DRGs are set low relative to their actual costs whereas the prices of the truly low cost DRGs are set high relative to their costs.

To determine whether compression is occurring, I first examine the algorithm that the Health Care Financing Administration (HCFA) used to set DRG relative prices. I then discuss some of the reasons the Medicare DRG relative prices may be compressed. Next, I compare HCFA relative prices with similar prices that were derived with more accurate data. I conclude with a discussion of other approaches that might be used to set DRG relative prices.

The Design of PPS

Among the critical decisions that had to be made when PPS was designed were: which costs were to be covered, what the unit of payment was to be, and which method was to be used to set the payment rate for the unit of payment. It was decided that PPS should cover the operating costs incurred by a hospital in providing care to Medicare beneficiaries and that the unit of payment should be the DRG.

Determining the payment rate for a given DRG was less straightforward. First, the hospital's standardized rate had to be determined.

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This standardized rate is a function of the hospital's own costs, the average regional hospital costs, and the average national costs. To determine the hospital's standardized rate, the regional and national rates were adjusted for the location of the hospital (urban/rural), the wage rate in the area in which the hospital was located, and the size of the hospital's teaching program. To determine the hospital's payment rate for a given DRG, the hospital's standardized rate was then multiplied by the price weight affixed to that DRG. Over time the standardized rate will be based only on the average national cost of hospital care.

The structure of DRG prices as determined by the price weights is a feature of the PPS system that has received relatively little attention. Most of the analytical attention has been given to the DRG patient classification system and the setting of the standardized rate.[1] To some extent, the nature of DRG prices and the patient classification system are intertwined. Of the two, the classification system is probably more important, although the pricing structure is critical to the success of PPS.

Assume, for the sake of argument, that the classification system is perfect: that is, it groups together patients who are similar in terms of resource use so that a hospital will make profits (or incur lower losses) if it treats more patients in DRGs for which the payments are high relative to the true cost of treating them. If some prices are set artificially high or low relative to those costs, the incentives facing the administrators, from a social perspective, will be distorted. These incentives will be stronger as hospitals face financial pressure (triggered, say, by the phase-in of PPS to the national rate or by a limitation on the overall rate of increase of rates in general).

Table 1. Calculation of adjusted cost

Data source			
Hospital bill		Medicare cost report	Results
Routine length of stay	×	Routine per diem cost	Routine cost
Special care unit length of stay	×	Special care unit's per diem cost	Special care costs +
Ancillary charges[a]	×	Ancillary department cost/charge ratio	Ancillary costs
			Adjusted cost

Source: Adapted from J. Pettengill and J. Vertrees, "Reliability and Validity in Hospital Case-Mix Measurement," *Health Care Financing Review* 4, no. 2 (1981): 107.

[a] This calculation was done for the following departments: operating room, laboratory, radiology, drugs, medical supplies, anesthesia, and "all others."

The Medicare DRG Pricing Algorithm

HCFA derived DRG relative prices[2] by first determining cost weights from information it had from hospital cost reports and patient bills. Using data from a 20% sample of 1981 Medicare bills (the 1981 MEDPAR file), HCFA analysts first estimated the adjusted cost for each patient by modifying each patient's bill with information from the cost report of the hospital in which the patient was treated. (The steps taken to make this adjustment are shown in Table 1.) They then normalized the adjusted cost according to the extent of teaching activity in each hospital and the area wage level. Finally, they grouped all cases in all hospitals into DRGs and, after excluding outliers on the basis of extreme values, calculated the average normalized adjusted cost per DRG. This generated the DRG cost weight. HCFA analysts then determined the relative DRG cost weight by setting the cost of the average case (DRG weighted) equal to one. To determine the prospective payment relative cost weight, they multiplied each DRG's relative cost weight by the ratio of the average expected hospital cost to the average cost per case. (In 1981, the year for which these calculations were done, the average cost per case was $2,176 and the average expected cost per hospital was $2,070.)[3] These prospective payment relative cost weights are the DRG relative prices.

The extent to which the DRG relative prices actually reflect the relative resource intensity of treating patients within the DRGs depends on both the nature of the data and the algorithm that was applied to that data. In an article describing the HCFA approach, Pettengill and Vertrees present an extensive discussion of some of the problems in both.[4] In what follows, however, I focus on three reasons the estimated relative prices are likely to be compressed.

First, as shown in Table 1, routine and special care costs are computed for each DRG by multiplying the length of stay for each type of care by the hospital's per diem cost for the relevant cost category. This assumes that the per diem routine costs and per diem special care costs are the same for each DRG. It seems likely, however, that a patient admitted for, say, hypertension (DRG 134) utilizes fewer routine nursing services than does a patient recovering from a major joint procedure (DRG 209) or abdominal surgery. Thus, the mix of patients seen probably affects routine care costs and perhaps special care costs as well. This conjecture is indirectly supported by the work of Fitzmaurice,[5] who found that, after many other factors were controlled for, routine nursing salary costs per day were significantly related to the Medicare Case Mix Index, a measure of the relative costliness of a hospital's patients. Thus, the cost weight of the truly high cost cases is probably too low and that of the truly low cost cases is too high.[6]

Second, there is considerable anecdotal evidence that, at least until recently, hospitals set prices so that the more costly ancillary services were relatively underpriced.[7] There is alleged to be considerable internal cross-price subsidization, with the prices of high-volume, low-cost services set to subsidize the price of low-volume, high-cost procedures. Thus, depending on how pervasive this practice is, the adjusted cost for truly high cost patients who are more likely to use high-cost services is set relatively low.

Third, in 1981, the year for which the prices were calculated, there were extensive errors in the diagnostic codes reported to HCFA. This is not surprising, because the diagnostic information was used only for reporting purposes and was of no real importance to the hospitals. An Institute of Medicine study[8] estimated that approximately 20% of the records in the MEDPAR file may have an erroneous principal diagnosis at the DRG level. The effect of this erroneous reporting can be shown in the following simplified example.

Suppose there are only two DRGs, simple and complicated, which constitute 80% and 20% of patients, respectively. Further, suppose that 20% of the diagnoses of each group are reported inaccurately. Thus, of 100 cases, the 80 truly simple cases and the 20 truly complicated cases will be reported as 68 simple and 32 complicated cases. If the true cost of a simple case is \$5,000 and the true cost of a complicated case is \$10,000, the calculated average cost for simple and complicated cases will be \$5,294 and \$7,500 respectively. This kind of data error means that the farther away a DRG is from DRGs whose true average costs are close to the mean (and thus patients in both higher and lower DRGs will be included in the DRG), the more biased the estimated cost of the DRG will become.

The data problems are compounded by the fact that when the relative price structure was created, the HCFA data contained only an indicator of secondary diagnosis. Because specific secondary diagnostic information was not coded, the assignment of a patient to a DRG with complicating or comorbid conditions was likely to be inaccurate. The data that HCFA integrated with its data to determine the cost weights to be assigned to DRGs with complicating or comorbid conditions have probably created bias in the estimated cost weights.

It is difficult to estimate the relative importance of each of these factors to compression in relative prices. However, I would guess that the first and third factors are more important than the second. Without considerably more data, however, and in the absence of a thorough analysis of the DRG pricing structure, it is impossible to identify which DRGs are likely to be overpriced or underpriced.

Comparison With Relative Prices Computed From Other Data Sets

To assess whether compression in Medicare DRG relative prices is likely to be a serious problem, I obtained or calculated three other sets of relative weights and compared them with the HCFA weights.

One set of weights was derived from the hospital bills of Medicare patients in Maryland from 1979 to 1981. The DRG cost weights were calculated from those data using an algorithm somewhat similar to HCFA's.[9] These relative weights should be somewhat more accurate than HCFA's for two reasons. First, the clinical information reported on the bill included both primary and secondary diagnoses, and thus the patients could be more accurately assigned to comorbid DRGs. In addition, the

Table 2. Statistics on DRG relative prices

Data	Mean	Standard deviation	Coefficient of variation
HCFA	1.2167	.8178	.672
Maryland Medicare	1.1465	.9207	.803
New Jersey teaching hospitals	1.1736	1.1167	.952
New Jersey nonteaching hospitals	1.2090	1.0936	.905

Table 3. HCFA relative weights against others

	Data set		
Variable	Maryland Medicare	New Jersey teaching hospitals	New Jersey nonteaching hospitals
Intercept	.270	.338	.333
b	.826	.707	.689
R^2	.86	.81	.74
Number of DRGs	395	463	463

clinical information may be more accurate because such data play an important role in the Maryland rate setting system for purposes of making adjustments to the base-year budget. Second, the Maryland charge data for a given service is probably more closely related to the cost of providing the service because the Maryland Health Services Review Commission directed hospitals to set prices so as to eliminate or reduce cross-subsidization. Thus, compression caused by the second and third factors above should be reduced.

I obtained the second set of data from New Jersey. This data set consists of two sets of adjusted costs—one for all teaching hospitals and one for nonteaching hospitals. These data may be superior to HCFA's for two reasons. First, because DRGs have been the basis of rate setting in New Jersey for some years, the New Jersey Hospital Rate Setting Commission has developed a more refined algorithm to calculate cost weights. Second, and more important, because hospital payment rates are based on DRGs, there is likely to be much less error in the diagnostic information reported by the hospitals. Thus, data used to estimate the cost weights of a given DRG in New Jersey are more likely to contain more patients who truly belong in the DRG than are the HCFA data. The New Jersey weights, however, are derived from the entire population, not just the Medicare population, which should spread out the weights more.

In order to compare these data, I calculated a set of normalized relative prices (NRPs). I first selected a DRG whose relative weight in the HCFA data set was close to one: DRG 135 (cardiac congenital and valvular disorders in patients over 69 and/or patients with complicating comorbidities) had a relative weight of .9922. I then set this weight in each data set equal to one. I recalibrated all other weights by dividing each weight by the weight of DRG 135. I then undertook two kinds of comparisons with HCFA's NRPs.

First, I examined the amount of variation in each set of NRPs. As can be seen in Table 2, there is slightly less variation in the HCFA NRPs than there is in the other data sets. Thus, the coefficient of variation is lowest in the HCFA data and highest in the New Jersey data.

Second, I examined the association between the HCFA NRPs and the other NRPs by regressing the HCFA NRPs against each of the other sets of NRPs.[10] I used fewer than 468 DRGs in the regression analysis because not all DRGs were represented in each data base. It will be observed in Table 3 that in each case the coefficient of the *b* statistic was less than one. Thus, the NRP of the highest-cost HCFA DRG is relatively low compared with the estimated cost of that DRG using other data, whereas the NRP of the lowest-cost HCFA DRG is relatively high compared with its estimated cost using other data. Thus, compared with DRG prices obtained from other data sets, the HCFA DRG prices are relatively compressed. As expected, this compression is more pronounced relative to the New Jersey data than the Maryland data.

Discussion

These results give strong support to the hypothesis that the current set of relative prices paid by HCFA is compressed. In practical terms, a hospital receives relatively less money to care for the most costly Medicare cases than it receives to care for the least costly patients. Thus, hospital administrators face distorted incentives. They may respond to these incentives by inappropriately cutting back services or by not admitting costly cases in the first place. In addition, hospitals that treat costly patients, on average, receive less money (relative to their costs) than do hospitals that treat relatively less costly patients. The distribution of Medicare payments across these hospitals is thus inequitable.

To some extent, the problems identified in this paper will be self-correcting if HCFA continues to use the same pricing algorithm. As a result of competitive pressures, it is likely that the prices set by hospitals for their individual services will become more reflective of the actual costs of producing those services. Also, since fiscal year 1983, it has been in the self-interest of hospitals to report accurate diagnostic information on their bills. Thus, when HCFA recalculates the DRG cost weights for 1986, as it is required to do by law, errors caused by the second and third factors will be mostly eliminated. Errors caused by the first factor, however, will remain. HCFA therefore should be encouraged to determine how much bias there is in the cost weights as a result of the method they used to allocate the routine and special case costs across the DRGs. If the bias is significant, research should be undertaken to determine methods of refining the costing algorithm to ensure that the cost weight calculated for a DRG reflects the use not only of ancillary services but also of nursing services.

There are, however, other approaches that could be used to recalculate DRG relative prices. In evaluating these other approaches, HCFA should weigh the improvements gained in the resulting price structure against the increased costs (if any) of obtaining different prices. I briefly discuss four alternative methods for recalculating the DRG price structure: 1) basing the relative price of a given DRG on the cost of appropriate treatment where a group of experts determines the appropriate treatment; 2) basing the relative prices on the actual hospital charges associated with treating the different DRGs; 3) basing the relative prices on the estimated cost of treating the different DRGs by an extensive determination of the costs of treating the DRGs in a subset of hospitals (microcosting); and 4) changing policy so that the relative prices paid for DRGs is the same across all hospitals. (One approach to the fourth method would be to make the prices paid to a particular hospital a function of a national weight along with the hospital's individual weight based on its cost of treating a given DRG. The weights in this case could be determined using either the current HCFA approach or the third or fourth method above.)

The first approach (which has already been studied)[11] is unlikely to be feasible on a national scale. It would be time consuming and difficult to obtain national consensus on appropriate treatment regimens for the different DRGs. The second approach would be easy to implement because charge data are collected on all Medicare cases. The value of the charge information as an approximation of costs, however, depends on the extent to which charges are used as the basis of payment in local areas and the extent to which there is significant competition among hospitals. The third approach is not one that has been pursued, so it is difficult to evaluate. It would be costly, however, to implement a cost-finding methodology in a sample of hospitals. If the DRG system is to remain in place over the long term, however, an effective method of validating the price structure must be developed.

The fourth approach has been proposed by the American Hospital Association. It is different from the others because it addresses some of the problems with the DRG patient classification system rather than the problems with the pricing system per se. Some of the DRGs are essentially heterogeneous,[12] so it is possible that hospitals do not admit a random group of patients within a given DRG but, rather, admit more relatively high cost or low cost patients within the DRG. Allowing DRG relative prices to vary across hospitals would help compensate for any systematic bias in the types of patients treated within a given DRG across hospitals.

Conclusions

The structure of the relative pricing system is an important aspect of the Medicare Prospective Payment System that has nonetheless received relatively little attention from analysts. The structure of the pricing system may create incentives for a hospital to admit and keep patients for whom the payments received are high or equal to its costs. Conversely, it may create disincentives to admit patients for whom the prices are on average low relative to costs. The incentive effects inherent in the pricing structure will become stronger if hospitals are put under financial pressure because of limits placed on the overall rate of increase or if a hospital is located in an area where the costs of providing care are relatively high, thus putting the hospital at a disadvantage when the national rates are phased in.

Over time, some of the factors leading to compression may be reduced or eliminated. Nevertheless, some compression is likely to remain. There are alternative ways of setting prices than that currently used by HCFA, such as basing Medicare prices on charges, estimating the cost of treating a given DRG, or using microcosting techniques to determine the cost of treating a given DRG in a subsample of hospitals. Of these, the most accurate but expensive and time consuming is the last. If in the long term, however, hospitals are to be paid on the basis of prospectively set prices for a set of products, some mechanism will have to be found to ensure that relative prices reflect relative costs.

Notes

This work was supported by a contract with Johns Hopkins University under a subcontract with the Commonwealth Fund project on the financing of teaching hospitals. The opinions expressed in this paper are those of the author and do not reflect those of Johns Hopkins University or the Commonwealth Fund. I would like to thank Rosanna Coffey of the National Center for Health Services Research for giving me the Maryland DRG cost weights. I would also like to thank Rosanna Coffey, Lester Lave, and Julian Pettengill for their comments and criticisms of earlier drafts.

1 See, e.g., the set of articles in *Health Care Financing Review*, 1984 annual supplement.

2 The DRG relative prices are the relative weights given in table 5 in the regulations implementing PPS; see the *Federal Register*, Sept. 1, 1983, esp. pp. 39768–39771.

3 Julian Pettengill, personal communication.

4 J. Pettengill and J. Vertrees, "Reliability and Validity in Hospital Case Mix Measurement," *Health Care Financing Review* 4, no. 2 (1982): 101–128.

5 M. Fitzmaurice, "A Statistical Analysis of the Medicare Routine Nursing Salary Differentials," *Health Care Financing Review* 5, no. 1 (1983): 45–64.

6 See also J. D. Thompson, "The Measurement of Nursing Intensity," *Health Care Financing Review* 1984 suppl., pp. 47–55.

7 Office of Technology Assessment, *Diagnosis Related Groups and the Medicare Program: Implications for Medical Technology* (Washington, DC: Government Printing Office, 1983).

8 Institute of Medicine, *Reliability of Medicare Hospital Discharge Records*, Publication NTIS PB 281680 (Washington, DC: National Academy of Sciences, November 1977).

9 The major difference between the HCFA algorithm and that used by Coffey and Goldfarb (*DRGs and Disease Staging for Reimbursing Medicare Patients*, working paper [Rockville, MD: National Center for Health Services Research, 1984]) is that the latter distributes routine costs across the DRGs on the basis of charges rather than costs.

10 The estimated model is:

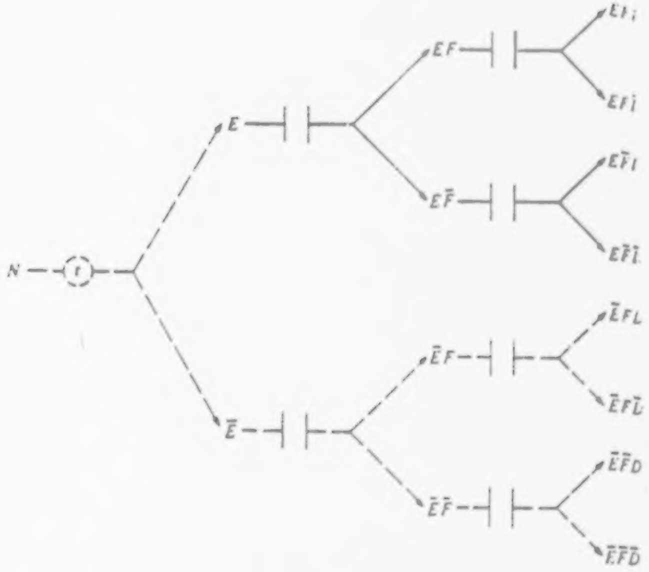
$$NRP_{HCFA,i} = a + bNRP_{Alt,i}$$

where *i* represents the DRG number and Alt stands for the NRP for the same DRG in the alternative data set.

11 W. W. Young, R. B. Swinkola, and D. M. Zorn, "The Measurement of Hospital Case Mix," *Medical Care* 29, no. 5 (1982): 501–512.

12 R. Frank and J. Lave, "The Psychiatric DRGs: Are They Different?" *Medical Care* (forthcoming).

Figure 5.11 Intervention Follow-up Study



risk factors or selection procedures have been controlled. However, the four types presented in this section—ecologic, proportional, and two types of cluster studies—are limited to designs for which information is missing on either the study factor, the disease, or their joint distribution in the study population.

Incomplete designs, especially ecologic and proportional, are frequently used when data are not readily available for conducting another type of study. It is often relatively inexpensive or convenient to make use of secondary data sources to test or generate hypotheses with these designs before spending considerably more time and money on primary data collection.

Most of the incomplete study designs were developed and applied before the widespread use of the basic or hybrid designs. While the essential features of these incomplete designs are rather simple compared with other designs, they involve a few key methodological subtleties that may seriously limit causal inference.

5.3.1 Ecologic Study

An *ecologic study*, also called an aggregate or descriptive study, is one in which the unit of analysis is a group, most often defined geographically (see Section 4.2.5). Ecologic analysis may involve incidence, prevalence, or mortality data, but the latter is most common because of the widespread availability of such data. The primary analytic feature of an ecologic study is that we do not know the joint distribution of the study factor(s) and the disease *within* each group (unit of analysis). That is, we know the number of exposed persons and the number of cases within each group, but we do not know the number of exposed cases.

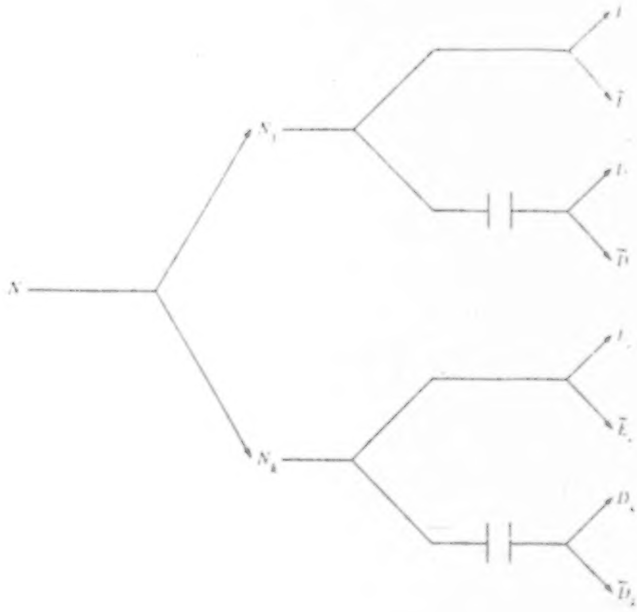
We may distinguish two types of ecologic studies: a simple comparison of frequency measures among k groups at one point in time or during one period (where k is usually large—e.g., $k \geq 10$), and an assessment of trends in one or more groups over time. In an *ecologic comparison study* (Figure 5.12), we estimate the frequencies of the exposure (E and $\bar{E}$) and the disease (D and $\bar{D}$) in each group. In an *ecologic trend* (or time series) study (Figure 5.13), we estimate the changes in both frequency measures during the study period. In addition, we may combine both types, estimating the change in average exposure level and the change in disease frequency for several groups.

EXAMPLE 5.5

Ecologic designs are most attractive when we must combine large data sources (e.g., the census and vital statistics) in order to obtain information on both the study factor(s) and disease for the same populations. For example, consider the work of the nineteenth-century sociologist Emil Durkheim (1951), who collected data on the frequency of suicides and the religious makeup of many contiguous provinces in Western Europe. He found that, on the average, provinces with greater proportions of Protestants had higher suicide rates and that provinces with greater proportions of Catholics had lower suicide rates. Durkheim concluded from these data that Protestants are more likely to commit suicide than are Catholics. While the conclusion may be true, the causal inference is not logically correct, because it may have been Catholics in predominantly Protestant provinces who were taking their own lives. This logical flaw, called the *ecological fallacy* (Selvin, 1958), results from making a causal inference about an individual phenomenon or process (e.g., suicide) on the basis of observations of groups. The problem occurs because the composition of each group is not homogeneous with respect to the study factor; e.g., most of the provinces in Durkheim's study included a substantial number of both Protestants and Catholics.

The ecological fallacy was first demonstrated mathematically, nearly [illegible] years after Durkheim's study, by another sociologist, William [illegible] (1950), who showed that the correlation between two ecologic [illegible] is often markedly different from the corresponding individual [illegible] within the same populations. More recently, other social scien-

Figure 5.12 Ecologic Comparison Study


N
N_1
N_k
E
$\bar{E}$
D
$\bar{D}$
E_k
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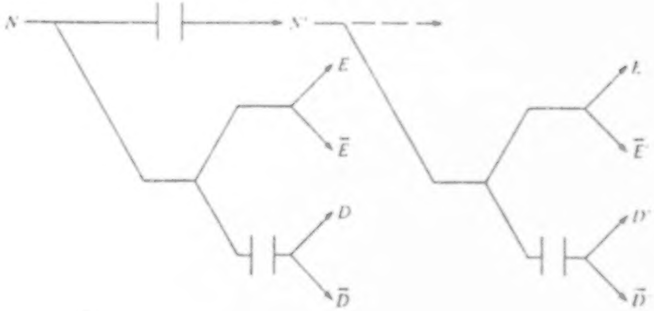
$\bar{D}_k$

Figure 5.13 Ecologic Trend Study


N
N'
E
$\bar{E}$
D
$\bar{D}$
E'
$\bar{E}'$
D'
$\bar{D}'$

ists have specified the assumptions required to make causal inferences from ecologic data (Goodman, 1953, 1959; Valkonen, 1969; Langbein and Lichtman, 1978; Firebaugh, 1978), and health researchers have begun to incorporate these ideas in their studies of disease etiology (e.g., Kalimo and Bice, 1973; Stavraky, 1976; Oreglia and Duncan, 1977).

The ability to make a causal inference from ecologic data often can be enhanced by comparing time trends in disease frequency among several groups that have experienced different changes in average exposure level. Suppose that Durkheim had found that the suicide rate increased only in provinces where there was a net immigration of Protestants and decreased only in provinces where there was a net emigration of Protestants, regardless of the original religious composition. We then might be less willing to ascribe the results to an ecological fallacy—i.e., we are more likely to infer that Protestants have a greater probability of committing suicide than do Catholics.

Unfortunately, the magnitude of the association between two sociodemographic variables tends to be substantially higher in ecologic analyses than it is in individual analyses (Stavraky, 1976). This problem of *multicollinearity* makes it very difficult to separate the effects of two such variables in the analysis. For example, Durkheim probably would have had trouble isolating the independent effects of religion and income on suicide rates because predominantly Protestant provinces had much higher average income levels than did Catholic provinces.

Despite their limitations for testing etiologic hypotheses, ecologic analyses are useful for evaluating the impact of intervention programs on the health status of target populations. Once the important modifiable determinants of a disease have been identified, the effectiveness of our public health initiatives to control that disease must be judged through ecologic assessment. In practice, however, we cannot completely distinguish between the testing of etiologic hypotheses and the evaluation of intervention strategies, because our knowledge of disease etiology is never complete. Consequently, ecologic studies generally are used to understand [illegible] phenomena at the same time they are used to test the application of knowledge.

5.3.2 Proportional Study

A *proportional or proportionate study* (Figure 5.14) is one that only includes observations on cases (*D*) without information about the candidate population at risk of developing the (index) disease(s) (MacMahon and Pugh, 1970, Chap. 5; Hill, 1971). The design may involve incident cases (proportional morbidity) or deaths (proportional mortality), though the latter is much more common because of the availability of mortality data. As indicated in Figure 5.14 the cases or deaths may be identified from the experience of a defined population (N); yet, study factor information is not obtained for noncases ($\bar{D}$), who were at risk of developing the index disease. Proportional studies may be regarded as either a special type of cross-sectional study (Hill, 1971; Kupper et al., 1978; Decouflé et al., undermine line authority; and (5) the fact that aspirants to higher staff offices could gain promotion only through approval of influential line executives.

If further research should prove that staff-line behavior of the character presented here is widespread in industry, and *if* top management should realize how such behavior affects its cost and production goals—and be concerned to improve the condition—then remedial measures could be considered. For example, a corrective approach might move in the direction of (1) creating a separate body[23] whose sole function would be the coordination of staff and line efforts; (2) increasing the gradations of awards and promotions in staff organizations (without increase of staff personnel); (3) granting of more nearly equal pay to staff officers, but with increased responsibility (without authority over line processes or personnel) for the practical working of their projects; (4) requiring that staff personnel have a minimum supervisory experience and have shared repeatedly in successful collaborative staff-line projects before transferring to the line; (5) steps by top management to remove the fear of veiled personal reprisal felt by officers in most levels of both staff and line hierarchies (This fear—rising from a disbelief in the possibility of bureaucratic impersonality—is probably the greatest obstacle to communication inside the ranks of management); (6) more emphasis in colleges and universities on realistic instruction in the social sciences for students preparing for industrial careers.

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[23] This body, or "Board of Coordination," would be empowered to enforce its decisions. Membership would consist of staff and line men who had had wide experience in the plant over a period of years. The Board would (a) serve as an arbiter between staff and line; (b) review, screen, and approve individual recommendations submitted; and (c) evaluate contributions after a trial period. Such a body would incidentally be another high status goal for seasoned, capable, and ambitious officers who too often are trapped by the converging walls of the pyramidal hierarchy.

ECOLOGICAL CORRELATIONS AND THE BEHAVIOR OF INDIVIDUALS

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INTRODUCTION

An individual correlation is a correlation in which the statistical object or thing described is indivisible. The correlation between color and illiteracy for persons in the United States, shown later in Table 1, is an individual correlation, because the kind of thing described is an indivisible unit, a person. In an individual correlation the variables are descriptive properties of individuals, such as height, income, eye color, or race, and not descriptive statistical constants such as rates or means.

In an *ecological correlation* the statistical object is a *group* of persons. The correlation between the percentage of the population which is Negro and the percentage of the population which is illiterate for the 48 states, shown later as Figure 2, is an ecological correlation. The thing described is the population of a state, and not a single individual. The variables are percentages, descriptive properties of groups, and not descriptive properties of individuals.

Ecological correlations are used in an impressive number of quantitative sociological studies, some of which by now have attained the status of classics: Cowles' "Statistical Study of Climate in Relation to Pulmonary Tuberculosis";[1] Gosnell's "Analysis of the

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[1] *Journal of the American Statistical Association*, 30 (Sept., 1935), 517-536.

1932 Presidential Vote in Chicago,"[2] "Factorial and Correlational Analysis of the 1934 Vote in Chicago,"[3] and the more elaborate factor analysis in *Machine Politics*;[4] Ogburn's "How Women Vote,"[5] "Measurement of the Factors in the Presidential Election of 1928,"[6] "Factors in the Variation of Crime Among Cities,"[7] and Groves and Ogburn's correlation analyses in *American Marriage and Family Relationships*;[8] Ross' study of school attendance in Texas;[9] Shaw's *Delinquency Areas* study of the correlates of delinquency,[10] as well as the more recent analyses in *Juvenile Delinquency in Urban Areas*;[11] Thompson's "Some Factors Influencing the Ratios of Children to Women in American Cities, 1930";[12] Whelpton's study of the correlates of birth rates, in "Geographic and Economic Differentials in Fertility;"[13] and White's "The Relation of Felonies to Environmental Factors in Indianapolis."[14]

Although these studies and scores like them depend upon ecological correlations, it is not because their authors are interested in correlations between the properties of areas as such. Even out-and-out ecologists, in studying delinquency, for example, rely primarily upon data describing individuals, not areas.[15] In each study which uses ecological correlations, the obvious purpose is to discover something about the behavior of individuals. Ecological correlations are used simply because correlations between the properties of individuals are not available. In each instance, however, the substitution is made tacitly rather than explicitly.

The purpose of this paper is to clarify the ecological correlation problem by stating, mathematically, the exact relation between ecological and individual correlations, and by showing the bearing of that relation upon the practice of using ecological correlations as substitutes for individual correlations.

THE ANATOMY OF AN ECOLOGICAL CORRELATION

Before discussing the mathematical relation between ecological and individual correlations, it will be useful to exhibit the structural connection between them in a specific situation. Figure 1 shows the scatter diagram for the ecological correlation between color and illiteracy for the Census Bureau's nine geographic divisions of the United States in 1930. The X-coordinate of each point is the percentage of the divisional population 10 years old and over which is Negro. The Y-coordinate is the

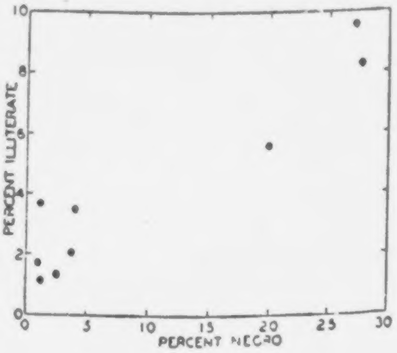

Fig. 1

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[2] *American Political Science Review*, 29 (Dec., 1935), 967-984.

[3] *Journal of the American Statistical Association*, 31 (Sept., 1936), 507-518.

[4] Chicago, 1937.

[5] *Political Science Quarterly*, 34 (Sept., 1919), 413-433.

[6] *Social Forces*, 8 (Dec., 1929), 175-183.

[7] *Journal of the American Statistical Association*, 30 (Mar., 1935), 12-34.

[8] New York, 1928.

[9] *School Attendance in the United States: 1920*, a supplementary report to the 1920 U. S. Census, Washington, 1924.

[10] Chicago, 1929.

[11] Chicago, 1942.

[12] *American Journal of Sociology*, 45 (Sept., 1939), 183-199.

[13] *Annals of the American Academy of Political and Social Science*, 188 (Nov., 1936), 37-55.

[14] *Social Forces*, 11 (May, 1932), 498-513.

[15] In Shaw's *Delinquency Areas*, for example.

percentage of the same population which is illiterate.[16] The Pearsonian correlation for Figure 1, i.e., the ecological correlation, is .946.

Table 1 is a fourfold table showing for the same population the correlation between color and illiteracy considered as properties of individuals rather than geographic areas. The Pearsonian (fourfold-point) correlation for Table 1, i.e., the individual correlation, is .203, slightly more than one-fifth of the corresponding ecological correlation.

Ordinarily, such an ecological correlation would be computed on a county or state basis, instead of the divisional basis used here to simplify numerical presentation. Whether the ecological areas are counties, states, or divisions, however, the results are similar. Figure 2, for example, shows the ecological correlation on a state rather than a divisional basis. When the ecological areas are states, as in Figure 2, the ecological correlation is .773, to be compared with .946 when the ecological areas are divisions.

TABLE 1. THE INDIVIDUAL CORRELATION BETWEEN COLOR AND ILLITERACY FOR THE UNITED STATES, 1930

(for the population 10 years old and over)[17]

	Negro	White	Total
Illiterate	1,512	2,406	3,918
Literate	7,780	85,574	93,354
Total	9,292	87,980	97,272

The connecting link between the individual correlation of Table 1 and the ecological correlation of Figure 1 is the individual correlations between color and illiteracy *within* the nine geographic divisions which furnish the nine observations for the ecological correlation. These are the *within-areas individual correlations,* a selection from which is given in Table 2.

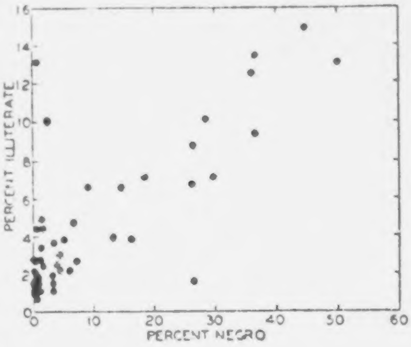

FIG. 2

Both the individual correlation and the ecological correlation depend upon the within-areas individual correlations, but in different ways. The individual correlation

TABLE 2. THE WITHIN-AREAS INDIVIDUAL CORRELATIONS BETWEEN COLOR AND ILLITERACY FOR THE UNITED STATES, 1930[18]

		Negro	White	Total
New England	Illiterate	4	240	244
	Literate	72	6,386	6,458
	Total	76	6,626	6,702
Middle Atlantic	Illiterate	32	719	751
	Literate	836	19,958	20,794
	Total	868	20,677	21,545
East North Central	Illiterate	36	392	428
	Literate	735	19,443	20,178
	Total	771	19,835	20,606
. . .	. . .	. . .	. . .	. . .
Pacific	Illiterate	2	71	73
	Literate	75	6,332	6,407
	Total	77	6,403	6,480

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[16] These percentages were computed from the marginal totals of the fourfold tables given in Table 2.

[17] The source for this and all following tables is the 1930 U. S. Census. All figures are in thousands.

[18] The tables for the West North Central, South Atlantic, East South Central, West South Central, and Mountain divisions are omitted to save space.

(Table 1) depends upon the internal or cell frequencies of the nine within-areas individual correlations. Its cell frequencies are sums of the nine corresponding divisional cell frequencies. For example, in the upper left cell of Table 1 the frequency is 1,512 = 4 + 32 + 36 + . . . + 2.

The ecological correlation (Figure 1) also depends upon the nine within-areas individual correlations, *but only upon their marginal totals*. For example, in Table 2 the marginal total for the first table shows 76,000 Negroes in the New England division. Since the total population for this division is 6,702,000, the percentage of Negroes is 100(76)/6,702 = 1.1. The percentage of illiterates in New England is computed from the other marginal total in the same way.

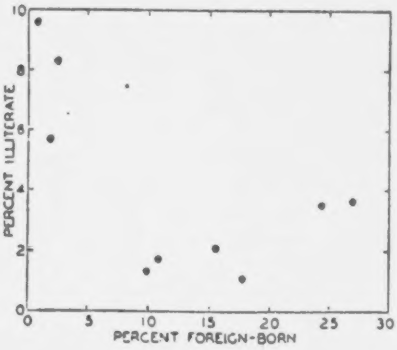

Fig. 3

In brief, the individual correlation depends upon the *internal* frequencies of the within-areas individual correlations, while the ecological correlation depends upon the *marginal* frequencies of the within-areas individual correlations. Moreover, it is well known that the marginal frequencies of a fourfold table do not determine the internal frequencies. There is a large number of sets of internal frequencies which will satisfy exactly the same marginal frequencies for any fourfold table. Therefore there are a large number of individual correlations which might correspond to any given ecological correlation, i.e., to any given set of marginal frequencies. In short, the within-areas marginal frequencies which determine the percentages from which the ecological correlation is computed do not fix the internal frequencies which determine the individual correlation. Thus there need be no correspondence between the individual correlation and the ecological correlation.

An instance will document this conclusion. The data of this section show that the individual correlation between color and illiteracy is .203, while the ecological correlation is .946. In this instance, the two correlations at least have the same sign, and that sign is consistent with our knowledge that educational standards in the United States are lower for Negroes than for whites.

However, consider another correlation where we also know what the sign ought to be, viz., that between nativity and illiteracy. We know that educational standards are lower for the foreign born than for the native born, and therefore that there ought to be a positive correlation between foreign birth and illiteracy. This surmise is corroborated by the individual correlation between foreign birth and illiteracy, shown in Table 3. The individual correlation for Table 3 is .118.

TABLE 3. THE INDIVIDUAL CORRELATION BETWEEN NATIVITY AND ILLITERACY FOR THE UNITED STATES, 1930

(for the population 10 years old and over)

	Foreign Born	Native Born	Total
Illiterate	1,304	2,614	3,918
Literate	11,913	81,441	93,354
Total	13,217	84,055	97,272

However, the ecological correlation between foreign birth and illiteracy, shown in Figure 3, is − .619! When the ecological correlation is computed on a state rather than a divisional basis, its value is − .526.

THE MATHEMATICAL RELATION BETWEEN ECOLOGICAL AND INDIVIDUAL CORRELATIONS

Individual and ecological correlations, along with other correlations which also play a part in the situation, are functionally related by one of the basic equations of the analysis of covariance.[10] This equation can be derived from the following assumptions, which merely describe in mathematical terms the situation underlying an ecological correlation:

(1) There is a total group of N persons, who are characterized by two variable properties X and Y. These properties may be genuine variables such as age or income, or they may be dichotomous attributes such as sex or literacy.

(2) The N members of the total group can be put into *m* distinct sub-groups according to their geographic position, whether by census tracts, townships, counties, states, or divisions. It is convenient to think of these *m* sub-groups as defined by *m* values of a third variable A (= Area) which is really an attribute, viz., geographic region.

The numerical values from which the ecological correlation is computed describe these *m* sub-groups. They may be means, medians, or percentages, and in fact all three are sometimes involved in a single ecological correlation analysis. Usually, however, they are percentages. While the mathematics applies to means as well, and approximately to medians also, it will simplify the present discussion to assume that X and Y are dichotomous properties, and therefore that the ecological correlation is a correlation between *m* pairs of percentages.

In the preceding section, three distinct correlations were shown to be involved in the ecological correlation situation. In mathematical terms, these correlations are described as follows:

The *total individual correlation* (r) is the simple Pearsonian correlation between X and Y for all N members of the total group, computed without reference to geographic position at all. If X and Y are dichotomous properties, the total individual correlation will be a fourfold-point correlation based on a fourfold table (Table 1).

The *ecological correlation* (r_e) is the weighted correlation between the *m* pairs of X- and Y-percentages which describe the sub-groups. In the example of Section 2, r_e is the correlation between the nine percentages of Negroes and the nine corresponding percentages of illiterates. However, each cross-product of an X- and Y-percentage is weighted by the number of persons in the group which the percentage describes, to give it an importance corresponding to the number of observations involved.

Ordinarily, ecological correlations are computed without the refinement of weighting. While the weighted form is theoretically more adequate, and is required by the mathematics of this section, the numerical difference between the two is negligible. The weighted ecological correlation for Figure 1, which involves few observations and should therefore be very sensitive to weighting, is .946, while the corresponding unweighted value is .944.

The *within-areas individual correlation* (r_w) is a weighted average of the *m* within-areas individual correlations between X and Y, each within-area correlation being weighted by the size of the group which it describes.

Two correlation ratios, η_{XA} and η_{YA}, are also involved in the relation. Their purpose is to measure the degree to which the values of X and Y show clustering by area. If X is a dichotomous property, say illiteracy, then a large value of η_{XA} indicates wide variation in the percentage of illiterates from one area to another.

With these definitions, the relation between individual and ecological correlations may be written as

$$r_e = k_1 r - k_2 r_w, \qquad (1)$$

where

$$k_1 = 1/\eta_{XA}\eta_{YA} \qquad (1a)$$

and

$$k_2 = \sqrt{1-\eta_{XA}^2}\sqrt{1-\eta_{YA}^2}/\eta_{XA}\eta_{YA} \qquad (1b)$$

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[10] The derivation of this equation is not given here because of space limitations. Readers wishing a copy may secure one by sending a stamped, self-addressed envelope to W. S. Robinson, Department of Anthropology and Sociology, University of California, Los Angeles 24, California.

That is, the ecological correlation is the weighted difference between the total individual correlation and the average of the *m* within-areas individual correlations. In this weighted difference, the weights of the total individual correlation and the within-areas individual correlation depend upon the degree to which the values of X and Y show clustering by area.

Investigation of the relation given in (1) shows that an individual and ecological correlation will be equal, and the equivalency assumption will therefore be valid, when

$$r_w = k_3 r, \qquad (2)$$

where

$$k_3 = \frac{1 - \eta_{XA}\eta_{YA}}{\sqrt{1 - \eta_{XA}^2}\sqrt{1 - \eta_{YA}^2}} \qquad (2a)$$

However, the minimum value of k_3 in (2) is unity. Therefore (2) will hold, and the individual and ecological correlations will be equal, only if the average within-areas individual correlation is not less than the total individual correlation. But all available evidence is that (whatever properties X and Y may denote) the correlation between X and Y is certainly not larger for relatively homogeneous sub-groups of persons than it is for the population at large. In short, the equivalency assumption has no basis in fact.

The consistently high numerical values of published ecological correlations in comparison with the smaller values ordinarily got in correlating the properties of individuals suggest that ecological correlations have some reason for being larger than corresponding individual correlations. The relation given in (1) shows what this reason is, for it gives as the condition for the numerically larger value of the ecological correlation

$$r_w < k_3 r, \qquad (3)$$

where k_3 is given by (2a). Since the minimum value of k_3 is unity, equation (3) implies that the ecological will be numerically greater than the individual correlation whenever the within-areas individual correlation is not greater than the total individual correlation, and this is the usual circumstance.

Habitual users of ecological correlations know that the size of the coefficient depends to a marked degree upon the number of sub-areas. Gehlke and Biehl, for example, commented in 1934[20] upon the positive relation between the size of the coefficient and the average size of the areas from which it was determined. This tendency is illustrated in Section 2, where the ecological correlation between color and illiteracy is .773 when the sub-areas are states and .946 when the sub-areas are the Census Bureau's nine geographic divisions. The same tendency is shown by the correlations between nativity and illiteracy, the value being −.526 on a state basis and −.619 on a divisional basis.

Equation (1) shows why the size of the ecological correlation depends upon the number of sub-areas, for the behavior of the ecological correlation as small sub-areas are grouped into larger ones can be predicted from the behavior of the variables on the right side of (1) as consolidation takes place. As smaller areas are consolidated, two things happen:

(1) The average within-areas individual correlation increases in size because of the increasing heterogeneity of the sub-areas. The effect of this is to *decrease* the value of the ecological correlation.

(2) The values of η_{XA} and η_{YA} decrease because of the decrease in the homogeneity of values of X and Y within sub-areas. The effect of this is to *increase* the value of the ecological correlation.

However, these two tendencies are of unequal importance. Investigation of (1) with respect to the effect of changes in the values of η_{XA}, η_{YA}, and r_w indicates that the influence of changes in the η's is considerably more important than the influence of changes in the value of r_w. The net effect of changes in the values of the η's and of r_w taken together, therefore, is to increase the numerical value of the ecological correlation as consolidation takes place.

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[20] "Certain Effects of Grouping upon the Size of the Correlation Coefficient in Census Tract Material," *Journal of the American Statistical Association*, 29 (Mar., 1934, Supplement), 169-170.

CONCLUSION

The relation between ecological and individual correlations which is discussed in this paper provides a definite answer as to whether ecological correlations can validly be used as substitutes for individual correlations. They cannot. While it is theoretically possible for the two to be equal, the conditions under which this can happen are far removed from those ordinarily encountered in data. From a practical standpoint, therefore, the only reasonable assumption is that an ecological correlation is almost certainly not equal to its corresponding individual correlation.

I am aware that this conclusion has serious consequences, and that its effect appears wholly negative because it throws serious doubt upon the validity of a number of important studies made in recent years. The purpose of this paper will have been accomplished, however, if it prevents the future computation of meaningless correlations and stimulates the study of similar problems with the use of meaningful correlations between the properties of individuals.

DURKHEIM'S *SUICIDE* AND PROBLEMS OF EMPIRICAL RESEARCH[1]

HANAN C. SELVIN

ABSTRACT

The theoretical content of *Suicide* has been thoroughly discussed, but relatively little attention has been paid to the ways in which Durkheim tested and refined his theories with empirical data. Durkheim's empirical analyses are multivariate: each additional variable is systematically incorporated into the relationships that have previously been studied. The analyses are also replicative: the same relationship is studied in widely varying contexts. A careful study of the consequences of these procedures, both intended and unintended, yields valuable insights into current problems of theoretically oriented empirical research.

Sixty-one years after it first appeared in print, Émile Durkheim's *Suicide*[2] is still a model of sociological research. Few, if any, later works can match the clarity and power with which Durkheim marshaled his facts to test and refine his theory. The stature of this work is even more impressive when one remembers that Durkheim lacked even so rudimentary a tool as the correlation coefficient. Yet the methodology of *Suicide* is important to those now engaged in empirical research, not merely to historians of sociology. Durkheim recognized and solved many of the problems that beset present-day research. Others he formulated so lucidly—perhaps because he did not exile his methodology to appendixes—that their solution is relatively simple with the tools now available. To use a fashionable term, this paper will explore some of the methodological "continuities" that stem from *Suicide*, much as the essays based on *The American Soldier*[3] and *The Authoritarian Personality*[4] have done with these more recent classics.

"Methodology" has several meanings to sociologists. To some it means questionnaires, interviews, punched cards—the hand tools of research. To others, such as Durkheim himself and Parsons,[5] it is the assumptions and concepts used in constructing a theory. Here it will be used to mean the systematic examination of the procedures, assumptions, and modes of explanation in the analysis of empirical data.[6] This focus on Durkheim's methodology is not meant to minimize the importance of his theoretical insights: the value of methodological investigations, after all, is that they lead to more effective theorizing about social behavior. But Durkheim's theoretical development has been discussed by many authors,[7] including others in this *Journal*, while his analytical procedures have not received the attention they deserve.

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[1] I am deeply indebted to Paul F. Lazarsfeld for acquainting me with the kind of analysis on which this paper is based.

[2] Émile Durkheim, *Suicide*, trans. John A. Spaulding and George Simpson (Glencoe, Ill.: Free Press, 1951).

[3] Robert K. Merton and Paul F. Lazarsfeld (eds.), *Continuities in Social Research: Studies in the Scope and Method of "The American Soldier"* (Glencoe, Ill.: Free Press, 1950).

[4] Richard Christie and Marie Jahoda (eds.), *Continuities in Social Research: Studies in the Scope and Method of "The Authoritarian Personality"* (Glencoe, Ill.: Free Press, 1954).

[5] Émile Durkheim, *The Rules of Sociological Method*, trans. Sarah A. Solvay and John H. Mueller (Glencoe, Ill.: Free Press, 1938); Talcott Parsons, *The Structure of Social Action* (Glencoe, Ill.: Free Press, 1949), pp. 20-27 and chap. ix.

[6] Paul F. Lazarsfeld and Morris Rosenberg (eds.), *The Language of Social Research* (Glencoe, Ill.: Free Press, 1955), p. 4.

[7] Parsons, *op. cit.*; Harry Alpert, *Émile Durkheim and His Sociology* (New York: Columbia University Press, 1939), Parts II and III; Émile Benoit-Smullyan, "The Sociologism of Émile Durkheim and His School," in Henry Elmer Barnes (ed.), *An Introduction to the History of Sociology* (Chicago: University of Chicago Press, 1948), chap. xxvii. His chapter contains a considerable bibliography.

MULTIVARIATE ANALYSIS

Central to Durkheim's methodology is his use of what has been called *multivariate analysis:* "the study and interpretation of complex interrelationships among a multiplicity of characteristics."[8] Much of the empirical analysis in *Suicide* can be viewed as the progressive introduction of additional variables. It will be useful to examine one of these analyses in detail, for it includes several of the procedures to be considered in this paper.

The first chapter on egoistic suicide (Book II, chap. ii) begins with the relation between religion and suicide rates for three groups of countries—the predominatly Protestant, the mixed Protestant and Catholic, and the predominantly Catholic.[9] But, as Durkheim points out, this comparison includes countries with radically different social conditions and requires consideration of the relation between religion and suicide *within* each country. Bavaria, the German state with the lowest proportion of Protestants, has the lowest proportion of suicides. And, in what may seem a mere piling-up of instances, the provinces within Bavaria also exhibit this same relationship: "Suicides are found in direct proportion to the number of Protestants and in inverse proportion to that of Catholics." Prussia and the Prussian provinces are the site of a similar analysis. Then the analysis is repeated for a third country: Switzerland. Here Durkheim takes advantage of the fact that both French- and German-speaking areas contain some cantons that are largely Catholic and others that are largely Protestant. This allows him to hold constant the effect of language as well as nationality ("race") while examining the effect of religion on suicide.

All the preceding analyses are based on data for nations or other large aggregations; thus the discussion of Bavaria cites the relatively high rate of suicides in provinces with high proportion of Protestants and the low rate in provinces with many Catholics. The implications of this procedure will be considered later; here it is important to note only that Durkheim recognized the difference between relationships based on aggregate data and those based on individual data, for he goes on to say that "in a fairly large number of cases the number of suicides per million inhabitants of the population of each confession has been directly determined." And he presents data on the suicide rates by religion for twelve periods of time in five countries, as well as some fragmentary data for France.

After disposing of the "deviant case" of Norway and Sweden, Durkheim considers the low suicide rate among Jews. As compared with Protestants and Catholics, Jews are more likely to live in cities and to pursue intellectual occupations—both conditions that are associated with higher suicide rates. Therefore, Durkheim reasons, if the reported rate of suicide among Jews is lower, despite these conditions, the "true" Jewish rate must be even lower than the figures reveal it to be.

As this passage makes plain, multivariate analysis meant more to Durkheim than simply considering the separate relationships between suicide and the several independent variables—religion, nationality, and language. Each new variable is progressively incorporated into the preceding analyses, so that several variables are considered jointly. The methodology of mutivariate analysis is most clearly seen in the case where a relationship between one independent variable (say, religion) and the dependent variable (suicide) is "elaborated" by the introduction of a third variable or "test factor" (say, nationality). Lazarsfeld, Kendall, and Hyman have defined three major types of elaboration: explanation, interpretation, and specification.[10] Explanation is the attempt to "explain away" the apparent meaning of an observed relationship. For example, the association between religion and suicide might have been a manifestation of nationality, since countries like Germany have both a high suicide rate and many Protestants. Looking into this possibility, Durkheim finds that the original association between religion and suicide persists when national differences are taken into account; nationality is therefore not an explanation of this relationship.

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[8] Lazarsfeld and Rosenberg, *op. cit.*, p. 11.

[9] This and the following two paragraphs are taken from *Suicide*, pp. 152-56.

[10] Paul F. Lazarsfeld, "Interpretation of Statistical Relations as a Research Operation," in Lazarsfeld and Rosenberg, *op. cit.*, pp. 115-25; Patricia L. Kendall and Paul F. Lazarsfeld, "Problems of Survey Analysis," in Merton and Lazarsfeld, *op. cit.*, pp. 133-96, esp. pp. 135-67; Herbert H. Hyman, *Survey Design and Analysis* (Glencoe, Ill.: Free Press, 1955), chaps. vi and vii.

Once convinced that nationality and language do not explain away the association between religion and suicide, Durkheim turns to the interpretation of this relationship: what is the chain of variables connecting two such disparate phenomena as Protestantism and a high suicide rate? A spirit of free inquiry, according to Durkheim, is the most important link in this chain: Protestantism fosters free inquiry and free inquiry in turn leads to a higher rate of suicide.

Although Durkheim lacked the statistical techniques to develop these ideas rigorously, he saw their central place in theoretically oriented research. The relationship between two variables ". . . may not be due to the fact that one phenomenon is the cause of the other but to the fact that they are both the effects of the same cause, or, again, that there exists between them a third phenomenon, interposed but unperceived, which is the effect of the first and the cause of the second."[11]

Specification, the third mode of elaboration, identifies the conditions under which a relationship holds true in greater or less degree. For example, the effect of religion on suicide is less in the German cantons of Switzerland than in the French. Since specification appears in many forms in *Suicide* and since its role in the development of sociological theory differs from the other modes of elaboration, it will be considered at some length.

Specification leads to the development of multivariate theories of behavior in a way that is not true of explanation and interpretation. The aim of specification is to construct three-variable relationships—to say that, as in the example just cited, the effect of religion on suicide is greater in one place than in another. Note that this statement cannot be decomposed into a set of two-variable relationships. Explanation, on the other hand, involves a three-variable association only as an intermediate step, either toward rejecting the apparent finding or toward affirming its provisional meaning; in either case, the result is not a three-variable relationship. Interpretation, likewise, uses the three-variable association only to produce a series of two-variable relationships, to show that these relationships are linked by the variables they have in common.

This greater complexity of specification, its essential three-variable nature, leads to more complex problems in analysis. Durkheim's successes and failures in coping with some of these problems are instructive. Three problems will be considered: (1) the joint effects of group and individual characteristics on individual behavior; (2) the theoretical problems stemming from the statistical concept of "interaction"; and (3) the question of when to stop an empirical analysis.

The variety of analyses that come under the heading of specification is suggested by Hyman's classification: among other ways, one can specify a relationship according to the interest and concern of respondents, the time and place at which it occurs, or the conditions and contingencies on which it depends.[12] Durkheim's analysis provides still another type based on the "units of analysis." This type of specification of which there are several varieties, has been called "contextual analysis":[13] it involves the joint effects of an individual characteristic and a group characteristic on rates of individual behavior. In discussing the lower suicide rate among married people, Durkheim points out that in France the difference between the married and the single (his "coefficient of preservation") is greater among the men, while in the Grand-Duchy of Oldenburg it is greater among the women.[14] That is, the social and cultural differences between France and Oldenburg are manifested in two essentially different ways: (1) They exert a *direct* effect; the over-all suicide rate is noticeably higher in France than in Oldenburg. (2) They exert an *indirect* effect; the *relationship* between sex and suicide is different in France and in Oldenburg. In other words, national characteristics have a differential impact on the sex-suicide association in the two countries, the difference between the sexes being greater in France than in Oldenburg.

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[11] *Rules*, p. 131.

[12] Hyman, *op. cit.*, pp. 295–311.

[13] Hanan C. Selvin and Warren O. Hagstrom, "Contextual Analysis: The Joint Effects of Group and Individual Characteristics on Behavior" (in preparation). I am indebted to Robert K. Merton for first calling my attention to the necessity of specifying the social context of a relationship between individual characteristics.

Methodological devices like contextual analysis are more than ingenious ways to manipulate data. As Merton has emphasized, they are important in opening new directions for theory.[15] Durheim's contextual analysis raises questions about the ways in which group and individual characteristics interact to affect behavior. For example, under what conditions do national characteristics produce such a marked reversal in the association between individual attributes and behavior?

The negative side of this case can also be found in *Suicide:* where Durkheim lacked adequate statistical techniques, he was occasionally led into theoretical contradictions. At one point he asserts that "the relation between the aptitude for suicide of married persons and that of widowers and widows is identically the same in widely different social groups, from the simple fact that the moral condition of widowhood everywhere bears the same relation to the moral constitution characteristic of marriage."[16] But Durkheim's data on Oldenberg and France lead to the opposite conclusion—that the relation between the suicide rates of married persons and widows and widowers was *not* the same in the two countries. What Durkheim lacked and what has since become available is a precise conception of statistical interaction, the ways in which the association between two variables depends on the values of a third variable.[17]

Durkheim's treatment of statistical interaction and of the theoretical relationships that it measures is notably inconsistent. Sometimes, as here, he ignores the presence of interaction in his data. Elsewhere, he correctly notes its presence, remarking, for example, that seasonal differences in suicide are less pronounced in cities than in rural areas.[18] And in another place he assumes, without any evidence for or against his assumption, that the interaction of temperature and location is zero: ". . . if the temperature had the supposed influence, it should be felt equally in the geographical distribution of suicides."[19]

One possible reason for Durkheim's inconsistency is that he had not formalized his analytical procedures. In effect, each time he came to a case of specification, it had to be reasoned through from the beginning. Formalizations such as the Lazarsfeld-Kendall-Hyman types of elaboration enable the analyst to recognize the same principle at work in different instances and therefore to treat them similarly. Such formalizations also reveal a link between apparently disparate phenomena; thus the formal model of elaboration also illuminates the seemingly unrelated problem of when to stop an analysis.

Durkheim's treatment of "race" and suicide provides a case in point.[20] Arguing that the high rate of sucide in Germany "might be due to the special nature of German civilization," he decides to "see whether the German retains this sad primacy outside of Germany."[21] To this end he examines the suicide rates in the provinces of Austria-Hungary, in which German-speaking people range from 1.9 to 100 per cent. and finds "not the least trace of German influence" on the suicide rate. However, a close examination of Durkheim's data, particularly of the five provinces that have high proportions of Germans and disproportionately few suicides, leads to quite different conclusions. These provinces—Upper Austria, Salzburg, Transalpine Tyrol, Carinthia, and Styria—comprise the western part of present-day Austria. If these five contiguous provinces are removed, the Spearman rank correlation for the remaining ten provinces is 0.95, indicating an almost perfect relationship between the suicide rate and the proportion of German-speaking people.

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[14] *Suicide*, pp. 177-80.

[15] Robert K. Merton, *Social Theory and Social Structure* (Glencoe, Ill.: Free Press, 1949), chap. iii.

[16] *Suicide*, p. 307.

[17] The phenomenon of statistical interaction has been given many different names (e.g., specification, conditional relationship, differential impact, differential sensitivity, and non-additivity of effects).

[18] *Suicide*, p. 120.

[19] *Ibid.*, p. 115.

[20] *Ibid.*, pp. 86-87.

The important point here is not substantive but methodological. Durkheim stopped his analysis as soon as he found a "zero" relationship. This procedure is perhaps more common in research today. Small associations are considered a signal to turn to other matters, especially when the associations are not statistically significant. The reasoning behind this assumption is never made explicit, but it would seem to be that, if two variables are not associated when other items are left free to vary, they will not be associated when these other items are "held constant." That is, if the total association between two variables is zero, the partial associations will be zero. Sometimes this is true; often it is not. Hyman's passage on the "elaboration of a zero relationship"[22] indicates that this may happen when the two partial relations are approximately equal in size and opposite in sign. For example, a surprisingly small association between job satisfaction and participation in community organizations resulted from a positive association between participation and satisfaction among members of the working class and a negative association of approximately the same size in the white-collar class.

To my knowledge, Hyman's is the only published discussion of this problem. It may be useful, therefore, to make two further points suggested by Hyman's brief treatment. First, he implies that this kind of relationship is uncommon and even accidental. Actually, it may occur frequently under certain conditions—for example, in the kind of contextual analysis discussed above, where people are assigned to groups instead of being born into them or choosing them themselves. A study of leisure-time behavior in army training companies found that many small or zero associations between behavior and an individual characteristic, such as marital status, resulted from opposite and approximately equal associations in companies with different "leadership climates."[23]

Second, still another type of elaboration of a zero relationship may be ranged alongside the two identified by Hyman. A zero association between two variables may occur even when both partial associations are in the same direction. The hypothetical example in Table 1 shows that this case would interest the student of political behavior. At both levels of education, the people with more information tend to choose the Democratic party, yet the "collapsed" table of information and party affiliation without regard to education will show that, among both the more-informed and the less-informed, 50 per cent are Democrats. The two partial associations are positive (and about the same size); the total association is zero. Unrealistic as this example may be (although it could describe a university town with a Democratic newspaper), it does demonstrate the importance of looking into those zero associations that theory or previous research suggests should not have been zero. A zero association between two variables may therefore result from any one of three different conditions in the partial relationships: zero associations in both partials, equal and opposite associations, or associations in the same direction. Only the first of these is a signal to stop the analysis.

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[21] By today's standards Durkheim's table shows a moderately high degree of association. The Spearman rank correlation is 0.57. In general, Durkheim regarded anything much less than perfect rank correlation as "independent." The reason why he could demand and find such high levels of association, while survey researchers are content with much less impressive relationships, has to do with the differences in the numbers of cases on which the associations are based. See the discussion of "grouping" in G. Udny Yule and M. G. Kendall, *An Introduction to the Theory of Statistics* (14th ed.; New York: Hafner, 1950), pp. 313–14.

[22] *Op. cit.*, pp. 307–10.

[23] Hanan C. Selvin, *The Effects of Leadership Climate on the Nonduty Behavior of Army Trainees* ("University Microfilms Publications," No. 19.256 [microfilmed Ph.D. dissertation, Columbia University, 1956]), Appendix F.

THE FUNCTIONS OF REPLICATION IN EMPIRICAL RESEARCH

Another multivariate procedure that is conspicuous in *Suicide* and that deserves intensive inquiry is *replication*, the systematic restudy of a given relationship in different contexts.

Again using the first chapter on egoistic suicide as an illustration, we find that the original table relating religion and suicide is followed by no less than the *seventeen* replications in three pages. Why so many replications? Durkheim's answer is not altogether clear. He does demand that the facts cited to support a thesis be "numerous enough not to be attributable to accidental circumstances—not to permit another explanation—to be contradicted by no other fact."[24] But these principles are not systematically explained. This section will therefore examine some of the uses of replications in *Suicide* and will consider what functions replications may serve in current research.

Durkheim's lavish use of replications is all the more noteworthy in contrast with modern survey research, where a relationship is often demonstrated only in a single table. One reason why Durkheim used so many replications is undoubtedly that his data came from official records; it cost him little more to study suicide in six countries than in one. On the other hand, in contemporary surveys the researcher must gather his own data, often at great expense, so that one community is a practical limit. However, as will be seen, this explanation rests on too narrow a conception of replications; a careful study of Durkheim's procedures will show that there are abundant opportunities for replication in every survey. A second reason for demonstrating a hypothesis in only one table is the belief that a close adherence to modern techniques of statistical inference—tests of significance, confidence intervals, and the like—guarantees the statistical soundness of the conclusions. This point of view has recently been vigorously attacked and staunchly defended.[25] Instead of repeating these arguments here, it will be shown that properly conducted replications may achieve the same ends more effectively. First, however, it is necessary to clarify the different kinds of replications.

"Unit replications" are the most frequent in *Suicide;* in these the original finding is

TABLE 1

INFORMATION AND PARTY AFFILIATION
EDUCATION HELD CONSTANT
(Hypothetical Data)

	LESS EDUCATED		MORE EDUCATED	
	Much Information	Little Information	Much Information	Little Information
Per cent Democratic	38	24	74	63
N	(200)	(100)	(100)	(200)

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[24] *Suicide*, p. 95.

[25] Hanan C. Selvin, "A Critique of Tests of Significance in Survey Research," *American Sociological Review*, XXII (1957), 519–27; David Gold, "Comment" and Hanan C. Selvin, "Reply," *American Sociological Review*, XXIII (1958), 85–86; James Beshers, "Comment" and Hanan C. Selvin, "Reply," *American Sociological Review*, Vol. XXIII (April, 1958).

re-examined for different groups of subjects—for example, the excess of military over civilian suicides is confirmed for eight different countries of Europe.[26] Durkheim further replicates this finding within the Austro-Hungarian Empire; the military-civilian difference persists in the various military areas.[27] These two examples suggest that unit replications may be divided into two subtypes: "external replications" and "internal replications."

In external replications the conclusions of one study are tested independently in another study, usually conducted by a different investigator.[28] Cross-cultural comparisons are a familiar example. Demographers and others who work with official records also conduct external replications as a matter of course. But this procedure is difficult and expensive for anyone who must gather his own data.

Just the opposite is true of internal replications, in which a finding is restudied for smaller groups within the original set of subjects. In the passage on military and civilian suicides there are several external replications, based on the different countries, and several internal replications for areas within one country.[29] Although these replications have a geographical basis, a finding may be replicated in groups formed on any set of variables. In the chapter on anomic suicide (Book II, chapter v), Durkheim presents a table of suicide rates by occupation for eight countries. Here the various countries act as external replications for his original finding on occupations and suicide. But the same table could also serve as an internal replication of the national differences considered in the earlier chapter on egoistic suicide, the comparisons between over-all national suicide rates being replicated for the comparable occupational groups within the countries.[30] Of course, all replications are not equally desirable; some criteria for choosing replications will be taken up after considering the uses of replications.

Replications, properly conducted, may serve at least two functions. They may provide a more valid "test of significance" where the usual tests cannot be legitimately applied, and they may lessen the seriousness of the "ecological fallacy," in which relationships between characteristics of individuals are wrongly inferred from data about groups.

REPLICATIONS AND STATISTICAL SIGNIFICANCE

Some reasons why tests of statistical significance are inapplicable in survey research have been noted in another paper.[31] Perhaps the most important reason—and the one that bears on the use of replications—is that the tests assume an experimental situation, in which differences between subjects can be randomized. Agronomists, for example, can convert constant differences in the fertility of their experimental plots into chance differences by randomizing the assignment of their plants; in effect, they toss a coin to determine whether a plant goes into the experimental plot or the control plot. But sociologists can seldom randomize. If Catholics are more numerous in Italy and Protestants in Germany, the sociologist must cope with these stubborn facts. He cannot randomly assign Protestants and Catholics to the two countries.

Randomization turns such systematic differences, or "correlated biases," into random differences. Tests of significance can then be used to measure the probability that the observed difference between experimental and control groups *could* have been produced by the accidents of randomization. Without randomization, these correlated biases remain as possible sources of the observed difference between the groups, along with the experimental variable whose influence is being measured. Thus the interpretation of the difference in suicide rates between Italy and Germany as the result of religious differences must take into account the many other differences between the two countries—education, cultural norms, and so on, which may account, in part at least, for the relationship between religion and suicide. Some of these differences could have been removed by cross-tabulation, had Durkheim had the necessary data. Others, not necessarily the least important, could not. Consequently, it appears misleading to ask for the probability that the observed relationship may be "due to change" without first being reasonably certain that correlated biases did not produce it.

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[26] *Suicide*, p. 228.

[27] *Ibid.*, p. 235.

[28] For a collection of external replications and an interesting treatment of the factors making for successful replications see Robert C. Hanson, "Evidence and Procedures Characteristics of 'Reliable' Propositions in Social Science," *American Journal of Sociology*, LXIII (1958), 357-70.

[29] *Suicide*, pp. 228-39.

[30] *Ibid.*, p. 258.

[31] Selvin, "A Critique of Significance Tests."

Replications, properly conducted, can take care of correlated biases and random errors at the same time. When Durkheim replicates within Germany the relationship previously studied among the various countries of Europe, he is removing the host of biases correlated with nationality. And when he further replicates within Bavaria and within Prussia, constant differences between these states no longer are mixed in with the religion-suicide relationship. Finally, his replications based on individual data remove some of the provincial differences. At each level of replication, additional correlated biases are controlled: the original relationship between religion and suicide gains more and more support.

Replications can thus lessen the likelihood that correlated biases may have produced the observed result. It is necessary only that the variable on which the replications are based be theoretically relevant (i.e., that there is reason to believe it is causally related to both the independent and the dependent variable). Now what of the random factors that may have produced the observed result? Here, too, replications are useful: they lead toward a valid test of significance which is simple to understand and easy to compute.

Consider once again the seventeen replications of the relationship between religion and suicide. How likely is it that this relationship resulted from some combination of random errors? That is, how often would one expect to find seventeen consecutive replications all showing Protestants more likely to commit suicide if, in fact, Protestants and Catholics are equally prone to suicide? Assuming that the replications are independent, that the outcome of one replication does not affect the outcome of another, the probability of such a series of replications is $(\frac{1}{2})^{17}$, a result significant at the 0.00001 level.[12]

Some cautions are in order. First, the validity of this computation, as of the ordinary test of significance, rests on the elimination of correlated biases. Since one can almost always conceive of relevant variables that have not been controlled and since there is no randomization to turn these correlated biases into random events, this condition is never fully satisfied. However, by applying this test only within series of replications, some, at least, of the correlated biases are controlled. The more variables that are controlled in any one replication, the more convincing this test of significance becomes.

Because he is dealing with official statistics that seldom are classifiable according to more than three variables, Durkheim's control over the correlated biases is relatively loose. Survey analysts, on the other hand, can more easily control these variables. For example, to test the hypothesis that socioeconomic status affects voting behavior, one would compare subgroups of high and low status that are similar on as many relevant variables as can be manipulated simultaneously. Such a test might compare two groups of young, single, urban,

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[12] Samuel A. Stouffer, "Quantitative Methods," in Joseph B. Gittler (ed.), *Review of Sociology* (New York: John Wiley & Sons, 1957), pp. 45–46. Stouffer's use of replications in *The American Soldier* (Princeton: Princeton University Press, 1949), I, 92–95, is a notable example (he refers to replications there as the "method of matched comparisons"). See also Selvin, *The Effects of Leadership Climate*, pp. 43–47, 183–204.

Protestant, male high-school graduates, one group of high socioeconomic status, the other of low status. This comparison would be repeated for all possible combinations of these six variables; if enough of these comparisons are in the same direction as the original relationship, one can be reasonably confident that the original relationship is not the result of random errors, assuming, of course, that there are no other important correlated biases.

In controlling for correlated biases, the subgroups should be formed on relevant variables; in testing for statistical significance, the subgroups should be independent. Consequently, if both criteria are satisfied, replications will tend to accomplish both tasks simultaneously. Relevance depends on the implicit or explicit theory that is being used, and no rules can guarantee it. On the other hand, independence can in general be insured by seeing that no individual appears in more than one subgroup in a given replication. For example, it would not be efficient to replicate Durkheim's religion-suicide relationship by studying it first among married and single men and then among older and younger men in the same country, for some man will appear in both sets of comparisons.[33]

One empirical procedure used by Durkheim appears at first glance to be another form of replication. In demonstrating that the relationship previously found between time of day and the suicide rate really depends on the "intensity of social life," he musters a variety of indicators of social activity—accidents, rail travel, and express receipts.[34] Social activity and suicide turn out to be highly associated, thus supporting his interpretation of the time-of-day relationship. Although this seems to be another type of replication, serving the same ends as those discussed above, this kind of item replication lacks one essential element of the unit replications: independence of observations. In fact, one does not even seek independence in item replications. These replications help to demonstrate that an indicator is *valid*—in other words, that it means what the analyst says it means. The greater the variety of indicators of social activity that Durkheim can relate to suicide, the greater his assurance that social activity—and not some accidental correlate of it—is what accounts for the variations in suicide.[35]

Replications thus serve Durkheim as a means of testing and refining his empirical hypotheses. The preceding discussion has suggested that they may serve these functions even better in survey research, where large numbers of variables can be easily manipulated. Another function of replications, of less general application but often of crucial importance in studies based on "ecological" data, will be examined in the following section.

REPLICATION AND THE "ECOLOGICAL FALLACY"

Robinson[36] first called the attention of sociologists to the fallacy of assuming that associations computed from group means or group proportions are valid estimates of the associations that would be obtained from individual data.[37] Most of Durkheim's tables are based on such fallacious reasoning. Thus he reports that the rate of suicide in departments of France varies according to the proportion of "persons of independent means."[38] This result is consistent with either of the following hypotheses: *none* of the people who commit suicide has independent means, or *all* of them have independent means. In this table the ecological association between characteristics of departments reveals nothing about the individual association between a person's wealth and whether or not he commits suicide.

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[33] Note that two or more time replications in the same table of *Suicide* are always separated by a period of years, thus increasing the independence of the replications.

[34] *Suicide*, pp. 118-20.

[35] Item replication is, in a sense, the inverse of scaling. In item replication, one begins with a concept and seeks a variety of indicators to clarify its meaning. In scaling, one begins with a set of items and asks whether there is a single underlying concept that accounts for them.

[36] William S. Robinson, "Ecological Correlations and the Behavior of Individuals," *American Sociological Review*, XV (1950), 351-57. This problem seems to have been discovered and treated independently in psychology, statistics, and economics, as well as in sociology, although not so fully as in Robinson's paper (see Edward L. Thorndike, "On the Fallacy of Imputing the Correlations Found for Groups to the Individuals or Smaller Groups Composing them," *American Journal of Psychology*, LII [1929], 122-24; Yule and Kendall, *op. cit.*, pp. 310-15; Kenneth H. Arrow, "Mathematical Models in the Social Sciences," in Daniel Lerner and Harold D. Lasswell [eds.], *The Policy Sciences* [Stanford: Stanford University Press, 1951], p. 134).

[37] Robinson's paper [illegible]

Every case of ecological associations does not entail the ecological fallacy. Menzel has shown that ecological associations are not only permissible but necessary when the "unit of analysis" is a group rather than the individuals in it.[39] However, Durkheim never theorizes about wealthy and poor departments, only about wealthy and poor individuals. And if he were interested in group characteristics—at the level, say, of departments or provinces—why would he replicate for successively finer subdivisions within these groups, in two cases carrying the replications down to individual data?[40] It is clear that Durkheim was guilty of the ecological fallacy.

To say that Durkheim's procedures were fallacious does not detract from his conclusions.[41] They may be true, even if they do not necessarily follow from his data. In effect, Durkheim recognized this problem and attempted to solve it in the only way open to him—the systematic use of replications for units smaller than those in his original relationship. When he was able to carry the replications down to individual data, there was, of course, no ecological fallacy: the hypothesis stated for group data is confirmed for individual data. However, even when Durkheim did not have individual data, the procedure of replicating in smaller units may lead, as Duncan and Davis have shown,[42] to useful estimates of the individual association.

Durkheim's data cannot be used to illustrate this procedure, for a reason to be stated shortly. Consider, instead, the following ecological data from a hypothetical city in which there are 20 election districts of 100 voters. Each of the first 10 districts has 10 per cent Republicans and 20 per cent voting for Eisenhower. (These are group attributes; nothing is said about the number of individuals who are both Republicans and for Eisenhower.) The other 10 districts are 80 per cent Republican and 90 per cent for Eisenhower. However one chooses to measure association—by product-moment correlation, percentage differences in a fourfold table, or any other index—this is a perfect ecological association: all the districts with many Republicans are for Eisenhower, as against none of the districts with few Republicans. This is formally the kind of relationship studied by Durkheim.

Now consider any one of the first 10 districts. The number of Republicans for Eisenhower is not known, but it is easy to see that it must be between a maximum of 10 and a minimum of zero. The corresponding values for the other 10 districts are 80 and 70. If each district had the maximum possible number of Republicans for Eisenhower, the total for the city would be $(10 \times 10) + (10 \times 80) = 900$; the minimum total for the city would be $(10 \times 0) + (10 \times 70) = 700$. Table 2 shows the maximum and minimum values for the four cells of the individual association. If the association between Republicanism and preference for Eisenhower is a maximum in each district, then, for the city as a whole, 100 per cent of the Republicans and 18.2 per cent of the

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sion and correlation, but the same problem arises, whatever the measure of association.

[38] *Suicide*, p. 245.

[39] Herbert Menzel, "Comment on Robinson's 'Ecological Correlations and the Behavior of Individuals,'" *American Sociological Review*, XV (1950), 674; see also the discussion of the "modifiable unit" in Yule and Kendall, *op. cit.*

[40] *Suicide*, pp. 154, 175.

[41] Andrew F. Henry and James F. Short, Jr., have made the most recent attempt to formulate a comprehensive theory of suicide in their *Suicide and Homicide* (Glencoe, Ill.: Free Press, 1954).

[42] Otis Dudley Duncan and Beverly Davis, "An Alternative to Ecological Correlation," *American Sociological Review*, XVIII (1953), 665-66.

Democrats prefer Eisenhower, a difference of 81.8 per cent. This is something less than the perfect ecological association; there, every Republican district was for Eisenhower and every Democratic district for Stevenson. Similarly, if the within-district associations are as small as possible, then 77.8 per cent of the Republicans and 36.4 per cent of the Democrats are for Eisenhower, a difference of 41.4 per cent.

The ecological data for the districts thus lead to bounds for the individual association in the city as a whole. Durkheim's procedure of replicating in successively smaller units would likewise seem to generate bounds for the individual associations on which his analysis is really based. In fact, Goodman has shown that the smallest units give the closest possible bounds; nothing would be gained in the example above by aggregating the districts into larger areas.[43] Durkheim's reason for replicating at several levels instead of going directly to the smallest units is probably that his data were uneven (i.e., that he did not have comparable figures for the provinces in all his countries).

TABLE 2

PARTY AFFILIATION AND VOTE
(Hypothetical Data)

INDIVIDUAL CANDIDATE CHOICE		INDIVIDUAL PARTY AFFILIATION		TOTAL
		Republican	Democratic	
Eisenhower......	Max.	900	200	1,100
	Min.	700	400	
Stevenson.......	Max.	0	900	
	Min.	200	700	900

The only difficulty in applying this procedure to Durkheim's data is that it will not work. Goodman's analysis indicates that bounds can be inferred only when the points in the ecological scatter plot are located in at least two of the four regions in Figure 1. The two sets of points for the hypothetical election data are located in regions *A* and *D*, as shown. But if the proportion for Eisenhower is replaced by the suicide rate and the proportion Republican by any one of Durkheim's independent variables (say, the proportion of Protestants), then all Durkheim's data are located in region *B*. (This is the region in which the suicide rate is less than the proportion of Protestants and also less than the proportion of non-Protestants.) No amount of replication, therefore, will lead to bounds for the individual association between suicide and Protestantism or between suicide and any of Durkheim's independent variables. Suicide is too rare an event, compared with the rates of the other variables he used. Ecological reasoning in *Suicide* is not limited to geographical data. "A proof of the slight effect of marriage [on suicide] is the fact that the marriage rate has changed very little since the first of the [nineteenth] century, while suicide has tripled."[44] Here, again, the real question is whether married people are more or less likely than single people to commit suicide. With these data, however, a positive, negative, or zero individual association is possible. Data aggregated over time can lead to false interpretations, just as can data aggregated over geographical units. In both cases the difficulty is removed by studying the data within units rather than "ecologically." There is no ecological fallacy when the independent variable and suicide are examined for individuals within each geographical area or for individuals within each time period. In other words, both versions of the ecological fallacy can be considered as cases of "spurious association." This, it will be recalled, is an erroneous inference that is "explained away" by holding constant a variable that accounts for both the items being studied. The associations between region and religion and between region and suicide may account for the ecological association between religion and suicide; holding region constant removes any possibility of a false inference from this association. Similarly, the association between suicide and the marriage rate may lead to false inferences unless it is examined within relatively short time periods.[45] There is thus a close methodological connection between problems of ecological association and procedures of multivariate analysis.

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[43] Leo A. Goodman, "Some Alternatives to Ecological Correlation" (Chicago: Statistical Research Center, University of Chicago, 1957) (dittoed). This comprehensive paper also includes another method for estimating the "individual regression" from ecological data under certain assumptions. Unfortunately, these assumptions are not met in Durkheim's data.

[44] *Suicide*, p. 185.

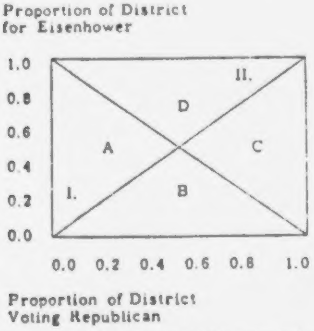

FIG. 1.—Conditions under which ecological associations yield bounds for individual associations.

This section has considered the uses of replications in testing sociological hypotheses and in making valid inferences from characteristics of groups to characteristics of their members. In both cases attention has been focused on the relationship of groups and subgroups; the description of the group, as given by Durkheim, has been taken for granted. But here, too, there are useful lessons to be learned from a careful examination of Durkheim's procedures.

A PROBLEM IN DESCRIBING GROUPS

The first section of the chapter on anomic suicide begins: "It is a well-known fact that economic crises have an aggravating effect on the suicidal tendency."[46] Durkheim then establishes that poverty is not the link between economic crises and suicide. He argues that poverty "tends rather *to produce the opposite effect*. There is very little suicide in Ireland, where the peasantry leads so wretched a life. Poverty-stricken Calabria has almost no suicide; Spain has a tenth as many as France."[47] Here is an association between groups (countries) and individual behavior, in which the relationship is attributed to *one* property of the groups—their poverty. But Calabria, Ireland, and Spain are not only poorer than France; they are also more Catholic than France and, as Durkheim was at pains to show in his analysis of egoistic suicide, less educated. There is no necessary reason why poverty should be singled out as the cause of the lower suicide rate in these countries. Religious or educational differences would have accounted equally well for the variations in suicide.

Essentially this same problem appears in different guise when one tries to infer the intensity of some form of behavior from data about its incidence. For example, Durkheim assumes that districts with high divorce rates have many families that are near divorce.[48] This statement may be true; it is not necessarily true. Two countries with the same average intensity of marital unhappiness may, because of their legal codes, have very different rates of divorce. To move legitimately from incidence to intensity in this way, one must take into account the other group characteristics that affect the dependent variable.

The source of these difficulties is clear. It is the oversimple description of a group according to a single variable. What can be done to avoid such problems? The obvious answer is to hold the other group characteristics constant by cross-tabulation, just as one does with individual characteristics. To study the influence of poverty on suicide, Durkheim would have had to find areas that were alike on other variables, such as religion, urbanization, and education, and different only in relative wealth. As a practical matter, this is impossible. Murdock's cross-cultural comparisons are based on as many as 250 different cultures, but even this number is too small to allow more than one variable to be held constant in any table.[49] The smaller the groups, the easier such statistical manipulation of group variables becomes, at least in principle. But surveys that study the joint effects of group and individual characteristics on behavior seldom have the resources to include the hundreds of groups that would be necessary if group characteristics were to be manipulated by cross-tabulation. (Studies based on census data can easily handle thousands of groups, but they do not often have data on the joint effects of individual and group variables.)

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[45] This is explanation in which the "ordering principle" is not "time" but "level of aggregation" or "level of complexity" (cf. Kendall and Lazarsfeld, *op. cit.*, p. 196).

[46] *Suicide*, p. 241.

[47] *Ibid.*, p. 245; italics added.

[48] *Ibid.*, p. 263.

If groups differing in only a single characteristic are practically impossible to find in survey research and if large numbers of groups are impossibly expensive, is there any alternative? The most attractive alternative—perhaps the only one—is to abandon the attempt to deal with one group characteristic at a time and to describe the groups with as many variables as necessary. Where the number of groups is too small for cross-tabulation, they should be described in terms of a multivariate typology.[50] In the first example above, for instance, Calabria, Ireland, and Spain would have been described not simply as poor but as poor, Catholic, and having a low level of education. Theoretical simplicity is thus sacrificed for theoretical and empirical accuracy. These countries would differ from France on three or more independent variables instead of one, but they would be described in all their relevant aspects.[51]

It is only fitting to close this argument for the typoldgical analysis of group characteristics by noting that here, too, Durkheim pointed the way. In his chapter "How To Determine Social Causes and Social Types" (Book II, chap. i), he argues for the classification of suicides, not as the simple act of killing one's self, but according to "morphological types" determined by the psychological and other characteristics of each suicide. It is only because the necessary data were not available that he was compelled to use his "etiological types." The same logic and the greater ease with which group data may now be gathered suggest that groups be described as multivariate types rather than by a single variable.

Despite its occasionally archaic language ("suicidogenic current"), the empirical analysis in *Suicide* is as vital today as it was in 1897—perhaps more so, since the quantitative approach that Durkheim pioneered has since become widely accepted among sociologists. But overemphasis on the quantitative aspects of *Suicide* would be as dangerous as total neglect, if it furthered the current tendency to substitute technical virtuosity for hard thinking about empirical data, thinking that is guided by theory and is directed toward enriching theory. This, after all, is the essential message of *Suicide:* that methodology is valuable insofar as it springs from the needs of theory and that theory is most fruitful when it is continually tested and refined in empirical research.

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[49] George Peter Murdock, *Social Structure* (New York: Macmillan Co., [illegible]).

[50] Allen H. Barton, "The Concept of Property-Space in Social Research," in Lazarsfeld and Rosenberg (eds.), *op. cit.*, pp. 40–[illegible].

[51] When the number of variables and the number of groups is as large as fifteen or twenty, it becomes economical to use factor-analytic procedures for determining the dimensions of the typology (see Andrew W. Halpin, *The Leadership Behavior of School Superintendents* [Columbus: College of Education, Ohio State University, 1956], pp. 3–10; Selvin, *The Effects of Leadership Climate*, pp. 11–39). The descriptions of group characteristics in these two works indicate that factor analysis is ideally suited to the study of groups, while it is at best a crude tool for the study of individuals. Briefly, the reason is that the correlations of group means and group proportions are virtually free from the idiosyncratic and random errors that attenuate the correlations of individual data, so that relatively few factors account for most of the variation in a large number of variables.

THE METHOD OF COMPUTING DIRECT COSTS OF DRGS DOES NOT CHARACTERIZE ACTUAL RESOURCE USE

The purpose of using DRGs as the basis for the Resource Allocation Methodology is to assign a reasonable payment for the care of a particular group of diagnoses that should have similar costs. It is assumed that costs should be the same for all Medical Centers for any specific DRG, irrespective of the mission, location, or other features of those Medical Centers. It has been recognized that several factors legitimately alter costs in different Medical Centers, and provision has been made so far to adjust payment somewhat for residency training and special pay rates. However, this still does not account adequately for all factors that affect actual cost to Medical Centers.

Several specific examples follow.

1. Medical Center A admits patient Jones because of unexplained bleeding in the skin. A blood count discloses that the patient has a very high white blood cell count and very low platelet count. The former leads to a diagnosis of leukemia, and within three days the patient is transferred to referral Medical Center B, which has an excellent Hematology/Oncology program. Medical Center B confirms the diagnosis and initiates the appropriate course of chemotherapy. For the next six weeks, the patient receives chemotherapy that produces a remission, and the patient returns home.

Both Medical Centers in this example will subsequently be funded the same number of dollars for the same DRG. In this case the DRG is #403, with funding of $2,591. However, based solely on a per diem cost of $400, the cost to the referring Medical Center is estimated to be $1,200, while the cost to Medical Center B is almost $17,000! As a result, Medical Center A will make a "profit" of $1,391, while Medical Center B will sustain a loss of over $14,000. Even these differences are conservative because (1) they are based on the incorrect assumption that per diem costs in both institutions were identical, (2) there was no provision for some of the extraordinarily expensive drugs such as cis-platinum ($3,000 for a single course of treatment), and (3) there is no accounting of the use of expensive portable pumps that provide continuous infusion.

2. The method by which "VA costs" are calculated for DRGs in surgery is as follows.

"VA cost" for DRGx = (ALOSx) (APD) + OR
DRGx = DRG for a specific procedure (x)
ALOSx = average length of stay for that procedure
APD = average per diem cost for all Surgery Bed Sections in the VA
OR = cost for use of operating room

Since the majority of surgery performed throughout the VA, as in the private sector, comprises relatively uncomplicated procedures, it is inevitable that the average per diem cost (APDx) is weighted toward these low expenditure admissions. Those procedures which require heavy use of resources, special equipment, long stays in the Intensive Care Unit, use of expensive prostheses, etc., are in the minority across the system as a whole and therefore do not contribute significantly to such a system average. The assumption underlying use of such an average presumably is that either all Medical Centers conform to the same distribution of relative costs or that longer lengths of stay for complex procedures compensate for the low average per diem cost. As shown in the attached Figure, there is a marked difference in the distribution of surgical procedures among different Medical Centers. In this Figure the frequency of procedures is plotted against relative complexity for each of the six Medical Centers in one District. The data clearly show that all Medical Centers do more of the simpler procedures, which therefore weights the average per diem cost toward the low end. Those three Medical Centers with large numbers of more complex procedures obviously will not do as well on funding as those with lowered frequency of such procedures.

Unfortunately for tertiary, referral centers with a relatively high proportion of expensive, complex procedures, the average per diem cost does not come close to accounting for actual expenditures. The reasons for this are several-fold.

a. A number of highly specialized surgeons must be on staff in order for the Medical Center to be able to provide highly specialized procedures. A Medical Center that is expected to be able to accept emergency referrals, for example, must have at least two staff surgeons in each specialty and subspecialty area to provide continuous coverage. In those situations where a true District or Regional referral center exists, more than two are often required. For some very complex procedures, it may even be necessary to have two experienced surgeons at the table simultaneously.

b. Certain kinds of procedures, such as open heart surgery, must be performed in relatively large numbers in order to maintain competence of the staff and thus control the frequency of complications.

c. The cost of some specialized equipment is very high for purchase, operation, and maintenance. In some cases, such as the bypass pumps used in open heart surgery, the technical personnel needed to operate them are in short supply, highly paid, and not available for other functions.

d. The cost of prostheses alone in cases such as joint replacements and heart valves exceeds the DRG funding or represents a very large fraction of it.

e. In order to provide continuous coverage for extremely ill patients, the clinical laboratory and radiology must operate 24-hours a day, a requirement that simply does not exist in less intensive settings.

3. A decision has been made to fund all one-day hospital admissions at a fixed rate of $360, presumably on the assumption that all such admissions do not expend a significant amount of resources. The reality, however, is that this group of admissions comprises a wide range reasons for admission, from "sleepers" on the low end of cost to surgery or endoscopy on the upper end. The cost of caring for a "sleeper" who is admitted because he resides a considerable distance away is relatively low. On the other hand, the cost of

some one-day procedures is very high and far outweighs those on the low side. Examples are many-fold: colonoscopy, coronary artery angiography, angioplasty, lens implant, cystoscopy, Mohs chemosurgery, endocrine testing, etc. In each case, one overnight stay is current practice to minimize hospitalization while assuring the absence of complications or to complete evaluation. On the other hand, a second or more days of hospitalization could be justified as a further precaution. A specific example of the difference in funding is as follows:

> One Medical Center performs 350 colonoscopies each year for suspected malignancy, a history of polyps, blood in the stools, or inflammatory bowel disease. Patients are observed overnight to be certain that no complications occurred and then are discharged. Total funding for these procedures is $126,000 (350 x $360). If these patients were to be admitted one day earlier for bowel preparation or kept in the hospital for an additional day of observation, the funding would be $529,391 according to the appropriate DRG, for a gain of $403,391!

It is clear that indiscriminate application of the one-day rule penalizes those Medical Centers that attempt to practice medicine in the most cost-effective manner. As a result, VAMCs will be forced by funding realities to alter practice in a direction opposite to existing efforts at cost containment.

4. No provision has been included in the RAM for the occurrence of epidemics, as has been strikingly evident with the current AIDS problem. Not only is there neither a DRG for AIDS nor an adequately funded DRG that could be used as a substitute, but the increasing number of patients cannot be accommodated by the current system of funding. The whole concept of funding based on a prior year's workload is clearly dependent on the assumption that workload and expenditures remain relatively constant from year to year. Such is obviously not the case where the number of patients doubles every year. Since each year's funding for a Medical Center is based upon its workload of two years previously, funding would cover only one-fourth of the current year's workload even if there were an appropriate DRG for AIDS. Patients with AIDS are extraordinarily expensive to treat, and this difference can represent a very large amount of money.

> At one of the major VA centers for AIDS, the anticipated shortfall for FY 87 is over $5 million! This figure was derived by examining the DRGs of AIDS patients hospitalized in FY 85 and subtracting this funding from the expected cost of caring for AIDS patients in FY 87. The same type of calculation was made for out-patient care. It is clear that, at this rate of resource utilization without proper funding, the Medical Center will be unable to keep its doors open for the full year.

5. The RAM includes a separate item for the cost of training residents. Unfortunately, the dollar figure selected appears to be arbitrarily low. Although it was theoretically based on costs reported by the individual Medical Centers via the 10-0141 report, these data are very soft and obviously subject to considerable local interpretation. In this regard, there are two substantive problems, as manifested by the extraordinarily wide range of costs reported:

a. Until this year, when education costs were split out as a separate item, there had been no particular reason to put much effort into disaggregating these costs on the 10-0141 or its predecessor 14-4 report. These numbers in the past had not made any difference in funding, so individual staff had often not bothered to try to estimate carefully their time for this purpose.

b. Although it is easy to identify lecture time as an element of education, it is very difficult to identify education time when it is an integral component of clinical care. Since the great majority of the training of residents occurs in the direct patient care setting, at the bedside or at the operating table, it is not at all clear how one should apportion time between education and practice. We make an effort to do this by asking individual physicians to calculate how much more time is taken by the education process over the time it would take them to provide the care personally. This obviously leads to highly subjective estimates of uncertain accuracy.

With these limitations in mind, it was decided by VACO in April 1986 that a reasonable value, based on the range reported by the Medical Centers, was about $39,000 per resident per year. This number was acceptable to most Medical Centers, even though many thought that it was low. In any case, the first distributed calculation of the of the RAM for FY 87 used a lower value of $24,000, the origin of which is unknown to the Medical Centers. Subsequently, this number was changed to $17,700 in the second calculation of the RAM, again without explanation other than its being a "technical" decision. For many Medical Centers this major change represents a very considerable loss of funds that they can ill afford.

6. A major source of problem for Medical Centers is the so-called "pass-through" accounts, which are not passed through at all. Pass-through accounts are those which are supposed to be funded fully, independent of the RAM calculations. This includes such items as protected programs (STAMP, Blind Rehabilitation, Comprehensive Rehabilitation Centers, etc.), fuel and utilities, fee basis, and research time of clinical staff. Unfortunately, these items are subject to reductions such as the 1% reduction for productivity. If a Medical Center protects absolutely its special programs from such reductions, then it is obliged to take a bigger fraction from the remaining items at risk. Such a scenario could be particularly damaging at those Medical Centers with a large number of special programs, as is most often the case at referral or tertiary Medical Centers with strong medical school affiliations.

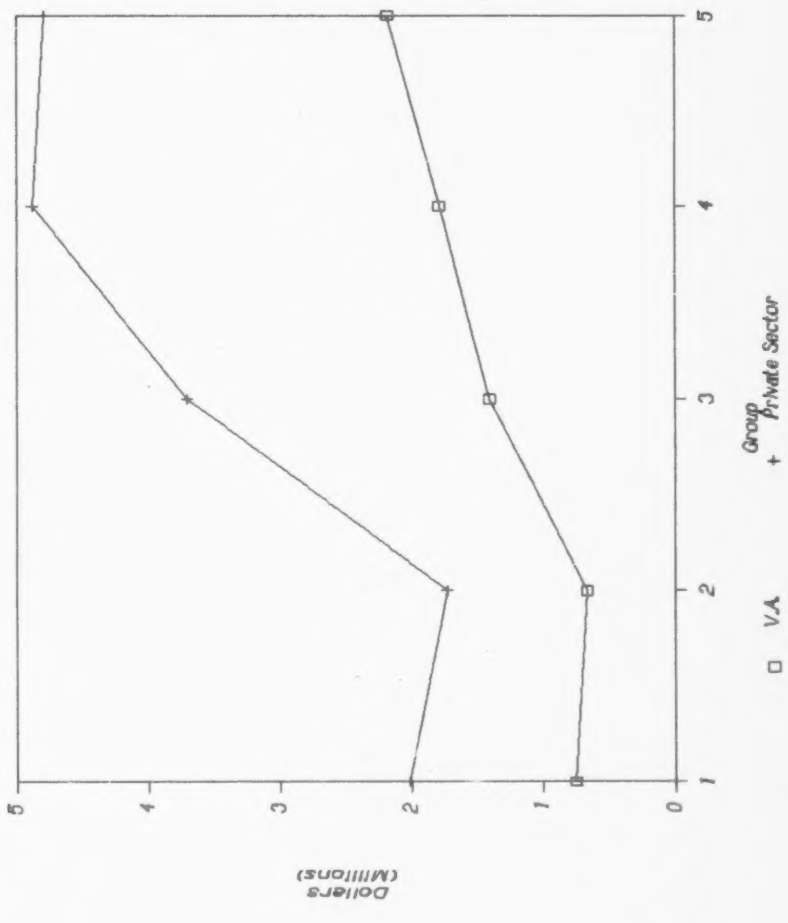
A very special worry is the research time of clinical staff, especially physicians, who generally are the largest number of investigators. It is generally accepted throughout the VA that physicians may legitimately spend as much as 25-30% of their time on research endeavors. Since most physicians at highly affiliated Medical Centers spend 55-60 hours per week in the hospital, even 30% research time would still leave 40 hours per week for clinical and teaching activities. In reality, however, even at the Medical Center with the largest research program in the VA, the average time spent on research by physicians is less than 18%. These salaries must be protected, since these are the same physicians who provide direct clinical care for the remaining 82%

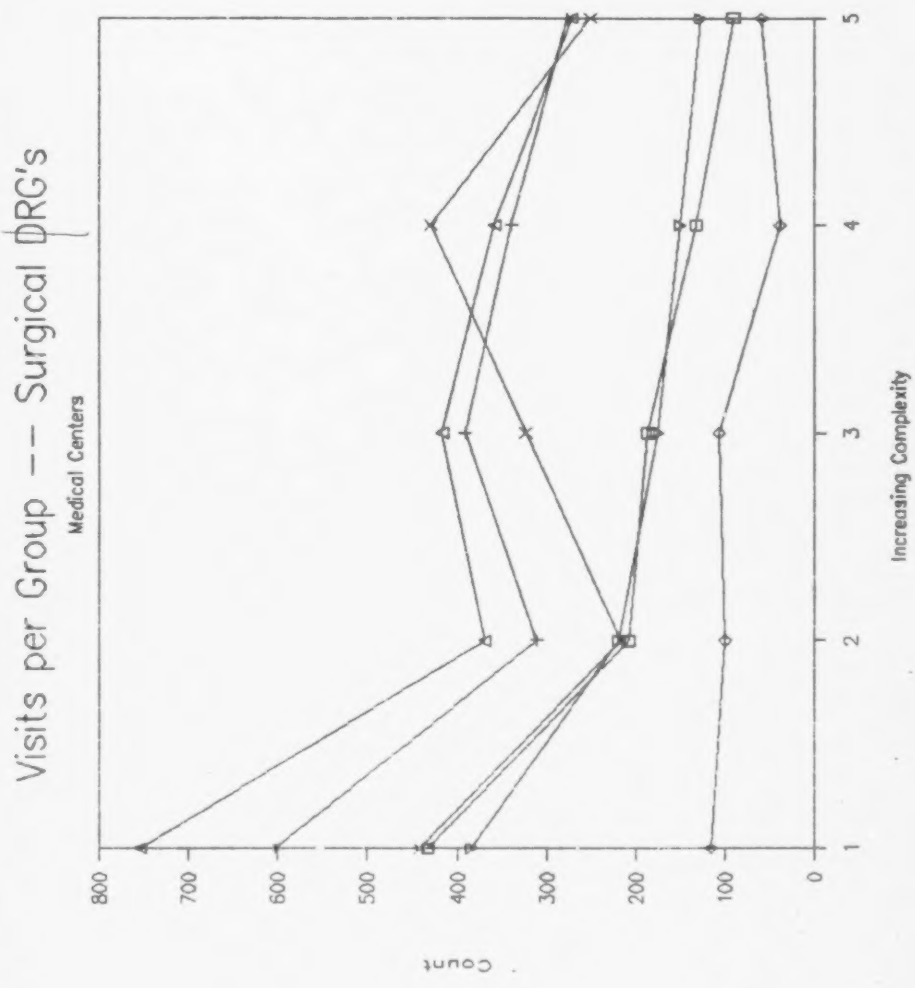
of their time. The net result of reductions in "pass-through" accounts, therefore, is enormous pressure to reduce clinical staff, a move that would be highly counter-productive and that would inevitably lead to decreased workload by the Medical Center.

7. It was mentioned above that special pay rates at individual Medical Centers were factored into the RAM calculation. Unfortunately, it appears from the data available that, as with DRG data, the special pay rates and personnel mix from two years previously are used in the calculation. As a result, those Medical Centers with periodic changes in special pay rates once again lose out in the RAM calculation by the use of outdated information.

By Ralph Goldsmith MD
January 1987

DRG REIMBURSEMENT FOR
SURGICAL PROCEDURES
V.A Vs. Private Sector




Visits per Group -- Surgical DRG's
Medical Centers
Count
800
700
600
500
400
300
200
100
0
1
2
3
4
5
Increasing Complexity

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

JOHN SOMMER, DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

HOUSE COMMITTEE ON VETERANS AFFAIRS

on

FISCAL YEAR 1988 BUDGET

FEBRUARY. 4, 1987

STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION THE AMERICAN LEGION BEFORE THE COMMITTEE ON VETERANS AFFAIRS U.S. HOUSE OF REPRESENTATIVES
FEBRUARY 4, 1987

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to set forth its views on the proposed funding for the Veterans Administration following an initial appraisal of the budget submitted to Congress by the Administration for fiscal year 1988.

The President has proposed for the Veterans Administration, budget authority of $27.575 billion, up approximately $475 million from FY 1987, and outlays of $27.045 billion, up nearly $135 million.

While this proposed increase in funding would appear to be a positive move on the part of the Administration, as this Committee knows there are a number of ill-considered proposals woven through the fabric of this budget, and each of them will be addressed in detail later in this statement.

Mr. Chairman, at the outset we feel it necessary to reiterate The American Legion's long-standing philosophy on the funding of veterans benefits and programs. This organization is totally committed to veterans, and therefore, stands for full funding for veterans programs; by which we mean there should be provision of such funds as are necessary to effectively carry out the programs that have been established by Congress. We support all of those programs. Each of them had a purpose when enacted, and each has been adequately justified as currently meeting a legitimate need of the veteran population. We are not aware of any programs at present that are superfluous or redundant.

Additionally, we feel it imperative to emphasize the fact that the portion of the total Federal budget consumed by veterans programs continues to decline, as it has consistently for the past twelve years. In FY 1975 the VA budget represented a full 5 percent of the total Federal expenditures, and in the current fiscal year it represents about 2.5 percent.

It seems that each year OMB devises new methods by which to attempt to whittle away at veterans programs. Thus we are grateful that the Congress, under guidance and counsel of the Veterans Affairs Committees, maintains a high level of responsibility in the formulation of the VA budget.

Before providing comment on specific budget items, which will be done for the most part in reference to the departments of the VA that administer them, we shall first address the legislative proposals set forth in the Budget message. They are a miscellany of old and new ideas, some of which seem to totally ignore the anticipated demand for essential benefits and services.

LEGISLATIVE INITIATIVES

- The Administration recommends a cost-of-living adjustment of 3.5 percent in compensation and related benefits to be effective December 1, 1987. The position of The American Legion is that these COLAs should be at least consistent with increases in the Consumer Price Index. The proposed 3.5 percent increase for those disabled in service - the most deserving of all Federal beneficiaries - is consistent with the current rate of inflation.

- The budget proposal contains an initiative that calls for veterans' disability compensation and survivors' DIC rates to be indexed, by statute, to automatically increase by the same percentage which Social Security benefits increase. The American Legion is opposed to the indexing of compensation and DIC benefits, and we have testified in opposition to identical proposals several times in the past. We have found that through the years, Congress has been fair and generous in providing annual cost-of-living adjustments in these benefits for the service-disabled and the survivors of service-deceased. Equally as important is the fact that the hearings by the Veterans Affairs Committees on legislation relating to the COLAs, provides a forum at which other legislation on issues such as Special Monthly Compensation eligibility criteria, and the development of additional presumptive disabilities may be discussed and deliberated.

# Another proposal would change the eligibility for the plot allowance, to make it consistent with the eligibility requirements for basic burial allowance. The American Legion is totally opposed to this idea. We feel that Congress made a mistake when it restricted the criteria for burial allowance. We are mandated to push for the restoration of the former eligibility criteria for the burial allowance to all veterans, and to increase the amount of the plot allowance.

# An amendment to section 806 of title 38, U.S.C. to authorize assumption by the VA of full responsibility for administration of the Veterans Mortgage Life Insurance program is proposed. We understand that under current law a private carrier acts as the insurer in this program, and it is reported that such an arrangement has proven costly and inefficient. In looking into this situation in more detail, we found that there are only about 6,000 veterans in this program, and approximately 200 claims are handled per year. Therefore, we see no reason why the VA Insurance Service cannot absorb this additional work, and we support the proposal.

# Proposed legislation would authorize the Department of Defense to budget all benefit costs associated with the new (peacetime) GI Bill. The American Legion is mandated to support this initiative. It is our position, and has been for several years, that the peacetime GI Bill should be funded by DOD, because it is a recruitment and retention tool for the Armed Forces, rather than a readjustment program as that term is defined, and administered by the VA, because that agency has in place the mechanism needed to efficiently run the program.

# An initiative to increase the loan origination fee under the VA Loan Guaranty Program is included in this proposal. We are opposed to the increase in this user fee from 1 percent to 2.5 percent. In addition, the Legion opposes the idea of making this a permanent fee by removing the sunset provision. Under current law authority to collect the fee terminates on September 30, 1987. We believe there are other means of assuring the solvency of the Loan Guaranty Revolving Fund, and we are prepared to continue to work with the Congress in developing them. The user fee cannot be viewed as anything other than a tax upon a traditional and economically useful benefit. This fee particularly impacts veterans with low to moderate incomes who would never be able to afford a home except through this program, as well as active duty military personnel whose families must periodically relocate.

Legislation will also be proposed to establish a lender/borrower negotiated interest rate with respect to VA home loans. We will oppose any change in the law that would allow the lender and veteran borrower to negotiate the interest rate on these loans. It is felt that this would adversely effect the interest rate charged to veterans who want to take advantage of the no down payment feature of the program. Further, we see nothing that would adequately protect veterans from unscrupulous lenders if such a practice were implemented.

# Proposed legislation would repeal the authority that permits VA to make education loans. This has been attempted several times in the past. Although an earlier cost-savings measure, the Omnibus Budget Reconciliation Act of 1981, limited the number of individuals eligible for VA education loans, those who retain eligibility and who depend on these loans could be forced to discontinue their program of education or training. Thus, The American Legion opposes this initiative as we have previously.

DEPARTMENT OF VETERANS BENEFITS

Direct benefit programs administered by VA through the Department of Veterans Benefits will consume 57 percent of the total VA budget in FY 1988. These programs are, for the most part, entitlements that statutorily must be funded, and they are benefits that are meeting the real needs of the veteran population they are intended to serve.

These benefits are administered through 59 regional offices. The proposed budget calls for a decrease in average employment in DVB of 296 FTEE. This includes FTEE losses of 255 in Compensation, Pension and Education; 95 in Veterans Services, and 16 in Vocational Rehabilitation and Counseling. Small FTEE gains of 30 in Insurance, 24 in ADP Systems Management, 12 in Loan Guaranty and 4 in Executive Direction are also proposed.

Mr. Chairman, if these employment reductions are enacted, the average employment in the Department of Veterans Benefits will have been reduced by well over

5,500 FTEE since FY 1979. This figure does not include the transfer of the Office of Data Management and Telecommunications into DVB, because ODM&T personnel are not involved in the hands-on delivery of benefits and services.

Time after time The American Legion has cautioned this Committee and others that the Department of Veterans Benefits cannot continue to accept consistent and persistent personnel cuts. These losses have caused innumerable problems in the regional offices, and are adversely impacting on the quality and timeliness of the delivery of benefits and services to veterans.

The summary accompanying the Budget Request states that the Department's employment request decreases by 296 FTEE in 1988, due to productivity improvements and an overall decline in workloads. It states that included in the 296 FTEE decline is 117 FTEE in modernization savings. The remaining 179 FTEE are attributable to caseload decreases and general productivity improvements in all benefit programs except Loan Guaranty. These caseload reductions, says the summary, are commensurate with our aging veteran population.

Mr. Chairman, this, in our opinion, is typical OMB boilerplate used to disguise the fact that there is an over $8 million savings associated with the proposed reduction in employment.

As we have stated in the past, The American Legion is supportive of economy of personnel in management, and maximum productivity by all Federal employees. However, the complexity of veterans claims has increased due in part to issues such as the effects of exposure to Agent Orange and ionizing radiation, and the pathology of post-traumatic stress disorder, just to name a few. The more complex the issue is the more man hours required per case. A certain minimum of personnel is needed to properly process cases, without delay-causing errors that have to be corrected; and productivity can only be used as a relative guide when considering the amount of work that must be done in the processing of a single case for an award of benefits.

The American Legion is not convinced that the Department of Veterans Benefits can operate effectively at the projected level of employment.

DEPARTMENT OF MEDICINE AND SURGERY

To The American Legion, there is no question that the most sensitive and vulnerable area of the Veterans Administration budget is the medical care program. This is because, unlike the direct benefit programs that are statutory, the viability of the medical care program depends entirely upon the appropriation of funds by Congress. Unfortunately, medical care is also becoming a target of the Administration's attempts to effect further cost savings.

The proposal for all medical programs for FY 1988 is slightly over $10.2 billion, representing 38 percent of the total VA budget. This is an overall increase of approximately $339 million over the current fiscal year funding. Direct medical care consumes the largest part of this funding at just over $9.9 billion. While on the surface this increase would appear to be adequate, one finds a number of shortfalls upon closer examination of the medical care account.

Let us begin with the fact that the Administration's figures are somewhat skewed, in that it has boasted a $414 million increase in medical care over the FY 1987 level - however, that is after the proposed rescission of $75 million from the FY 1987 medical care budget. The funds that are to be eliminated are those that would otherwise be used during the last five months of FY 1987 for the treatment of Category C veterans.

This proposed reduction was reported as Rescission Proposal No.: R87-70 in the Federal Register of January 9, 1987. We understand that the Congress has 45 days to act, subsequent to publication, and if no action is taken the monies must be made available by OMB.

With respect to FY 1988, OMB estimates that an additional $92.2 million and 2,350 FTEE can be saved, and 18.6 thousand would be treated under this proposal.

To The American Legion this is totally unacceptable. The Administration has stated that "the VA will continue to furnish care to nonservice-disabled veterans with incomes above $25,000 in locations where resources remain available". We truly believe that all veterans using the VA system would suffer under this plan. VA medical centers do not have a specific number of beds for each of categories A, B and C; they admit patients on the basis of medical need, and therefore the reduction of resources would have an adverse effect on all veteran patients.

Even more basic than this, however, is the fact that the Congress did not intend for category C veterans to be eliminated from the VA medical care system. PL 99-272 states that the Veterans Administration may furnish needed hospital and nursing home care to veterans in category C, who agree to pay a copayment, to the extent that resources and facilities are otherwise available. Nowhere in the legislative history of this law do we find even the faintest hint that the Congress felt that medical care funding should be reduced by an amount based upon the estimated number of category C veterans who may seek treatment from the VA. This is another case of OMB attempting to impose its will upon Congress.

The Administration's budget also includes a net personnel loss of 3,813 FTEE. Upon close examination of the figures for average employment, the situation looks even more dismal. Reductions of 4,267 FTEE in VA hospitals, 405 in outpatient services, 57 in miscellaneous benefits and services, and 4 from VA domiciliaries are proposed, as are increases of 913 in nursing home care units, and 7 in non-VA programs support. Of the 3,813 FTEE, 1,400 are to be eliminated during the last 5 months of FY 1987, along with the rescission of $75 million.

Mr. Chairman, The American Legion is totally opposed to any further reductions of health care professionals in the VA medical care system. During the past several years, OMB has used a variety of schemes in its attempt to shrink the Department of Medicine and Surgery. These have included personnel reductions based on inadequate funding, the implementation of programs such as the reduction of GS 11 through 15 positions, and by proposing to treat fewer "low priority" veterans. In reviewing the language of the FY 1988 summary of program resource changes, we see, aside from the projected loss of 2,350 FTEE based on the treatment of fewer category C veterans, other explanations given for personnel reductions such as a "savings" of 1,991 FTEE to be achieved through a projected one percent productivity increase.

In the opinion of The American Legion, further reductions in staffing will result in irreparable damage to the VA medical care system, and the erosion of the quality of medical care that is being provided this nation's veterans.

The budget proposal provides for approximately 1.4 million inpatient treatment episodes, and 20.4 million outpatient visits, decreases of 9,686 and 113,000 episodes respectively. According to the explanatory language these decreases are attributable to the elimination of category C veterans.

Unfortunately, we were unable to locate any specific figures in the budget documents, or from the VA relating to the proposed maintenance of average operating beds in the VA medical care system, other than a bar graph that shows a decrease in acute care beds, an increase in nursing home beds, and a decrease in beds overall, down to a level of 87.4 thousand.

As we have previously stated, the number of acute care beds within the system has continually eroded over the past several years, despite the precautionary statements presented by The American Legion that there should be no further reductions. As we have said in the past, this is a particularly bad time to be eliminating acute care beds, when aging veterans are increasingly experiencing catastrophic illnesses. Older persons almost always require treatment for an acute episode prior to the need for long-term care. It is obvious there is a need for more long-term care beds in the system. However, that does not connote a decreasing need for acute care beds. The system must maintain a substantial number of acute care beds if it is to retain its ability to meet the full mix of treatment needs required of it by its primary mission, and its ability to fulfill the agency's assigned mission as the principal contingency back-up to the Armed Forces medical programs in case of a national emergency or an outbreak of hostilities.

The beneficiary travel program reflects a "resource realignment" based on a "reform" of the program that began in FY 1987, equating to a reduction of $18 million from the program, leaving a proposed funding level of $50 million for FY 1988.

The American Legion is opposed to the proposed changes to the regulations relating to the beneficiary travel program and so stated its objections in a letter to the Administrator of Veterans Affairs dated December 3, 1986.

As restricted by the proposed changes, the disallowance of the benefit is going to result in poor veterans not being able to avail themselves of medical care from the Veterans Administration that they need and would otherwise receive. The resulting lack of medical care for this class of beneficiary will have two subsequent results, both bad for veterans and for the VA. Either the veteran will not seek medical care until his or her condition has become so serious as to require hospital admission, thus resulting in higher cost to VA for the provision of care; or the veteran will simply not seek needed care and thus shorten his or her life span.

As stated in our letter to the Administrator, justification for the proposed changes in beneficiary travel regulations is apparently based on the increasing cost of the program account, which was in excess of $100 million for the immediate past fiscal year. Concern at the escalating cost is understandable. In our opinion the increased cost can be ascribed to two principal factors: the increasing number of aging veterans who need medical care, and possible weaknesses in the administration of the benefit at the station level. As to the first cause, it is a demographic development that has been anticipated for a number of years, and nothing can be done about it. Older veterans are developing the need for more health care. Evidence of this fact is seen in the escalation of the number of outpatient visits provided by VA each year - now in excess of 18 million and rising. It is also true that poorer veterans become ill earlier and more seriously ill than veterans higher on the economic ladder. These are demographic factors that have been plotted for years. Poor veterans who are ill are either going to get needed care from VA, or from other publicly supported medical programs, or they are going to do without, with the resulting adverse consequences described above. Those who live furthest from sources of care are going to suffer the most. That is an obvious fact. In the case of veterans, the Federal Government, through VA has a direct obligation to help these veterans as much as possible, and to do that the beneficiary travel allowance is an essential factor.

With reference to the second factor mentioned above, weaknesses in the administration of the beneficiary travel allowance, The American Legion is aware that one of the problems with this benefit has been the potential for abuse and/or sloppy administration of the benefit. It is our judgement that this problem can be minimized with careful administrative procedures. The Legion is supportive of reasonable efforts to effect careful management at the station level, and in its capacity as a service organization that assists individual veterans seeking VA benefits, it pledges active assistance to VA in accomplishment of this goal.

It is the position of The American Legion that with careful management, substantial cost containment can be effected. It is also true, however, that continuing increase in the cost of the benefit must be expected as the large pool of surviving World War II veterans continues to grow older, and as the cost of travel, along with all other costs, continues to show some increase. This is a justifiable and reasonable increase in the cost of veterans benefits that should be accepted and provided by the Federal Government.

We are pleased to see that there has been some attention given to extended care programs in the budget proposal. These programs encompass a broad range of care which include nursing home care and domiciliary care in both VA and state facilities; hospital based home care, adult day health care, and community residential care. There is a proposed increase of nearly $32.9 million targeted for these programs.

However, in reviewing the Summary of Resource Increases/Decreases relating to the State home program, it is noted that there is no proposal relating to an increase in the per diem rates. The American Legion is mandated to support an annual review and revision of the rates of reimbursement by the VA for the care provided veterans in State veterans homes.

The last increases in per diem rates were set forth in PL 98-160, effective April 1, 1984. We are aware that 38, U.S.C 641(c) currently requires the Administrator to submit a report every three years to the Committees on Veterans Affairs on the adequacy of the per diem rates payable to each State for domiciliary, nursing home and hospital care for each veteran receiving such care in a State home. The first report was to have been submitted not later than June 30, 1986. The American Legion believes that the fair sharing of the cost of providing extended care for elderly and disabled veterans will encourage States to meet the needs of the aging veteran population, and we urge that the per diem rates be reviewed, keeping in mind that they have not been increased for three years.

Medical and Prosthetic Research

An increase of nearly $2.3 million in research funds is projected for FY 1988, up to $198.8 million.

It should be noted, as described in the budget document this appropriation provides funding for program activities in the following areas:

Medical research: Efforts in this area fall into two broad categories: research on medical, dental and psychiatric problems that are specific to the veteran population (spinal cord injury, Agent Orange, etc.); and research on general health problems that are particularly prevalent among veterans (e.g., alcoholism, aging and schizophrenia). Most of the investigators are VA clinicians and the close links between the research and patient care functions give the research program a clinical orientation that is directly related to its goal of providing quality medical care to the veteran patient.

Rehabilitation research: This program focuses directly on the needs of the veteran who is functionally impaired as a result of amputation, paralysis or the loss or impairment of his or her vision, hearing or speech. The latest computer and other technological advances are used to develop devices, techniques and concepts in rehabilitation that will minimize the disability and promote functional independence among disabled veterans.

Health services research: The goal of this research is to improve the effectiveness and efficiency of the Veterans Administration's health care delivery system. Health services researchers develop and disseminate information designed to help clinicians, investigators and administrators select medical interventions and administrative actions that are most appropriate to the Agency's mission, which is the provision of quality medical care services to the veteran patient.

The Veterans Administration's Medical and Prosthetic Research Program is a matter of particular interest to The American Legion, as a result of our sensitivity to the importance of research in the triad of the VA health care program: clinical care, education of health manpower, and research. These three functions cannot thrive independently - the presence of the other two are required. It would be impossible for the Veterans Administration to continue the provision of high quality medical care without a strongly funded research program. As this Committee knows, much of the research in which VA engages is basic research that is advantageous not only to veterans, but is of direct benefit to all mankind.

Average employment reflects a loss of 225 FTEE in medical research and no change in rehabilitation research and health services research, for a total of 4,417 FTEE. Available information does not reflect how these losses are to be accomplished. However, we are concerned, as we maintain that there is a need not for a reduction, but for an increase in available personnel for VA research activities. The Federal Government could make no wiser an investment than ensuring a vigorous and viable VA research program that benefits the entire American people.

GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

A decrease of $400 thousand, down to $42 million is proposed for grants for construction of State extended care facilities.

We are extremely aware of the importance of the services provided by State Homes, in that they have substantially reduced the burden that otherwise would have been borne by the Veterans Administration. There are now State homes in 35 States with 45 nursing homes, 43 domiciliaries, and 7 hospitals.

The FY 1988 request will provide for five projects which will produce an additional 371 nursing home and 450 domiciliary beds as well as 12 non-bed producing renovation projects in seven States.

In examining the program, we note that there is currently a backlog of 63 projects representing requests for grants of over $126 million. What this means is that if a State submits a request for a grant for funding of a project today, it may receive funds four to five years in the future.

The American Legion considers this program a wise investment, and when considering the ongoing efforts to reduce Federal spending, the role of the State Homes is even more significant. Therefore, we do not believe it wise to reduce the amount of funding to this program. As we move into the period of an aging veteran population that will be with the nation for the foreseeable future, the States can be of major assistance to the Federal Government in caring for this population through State extended care facilities. However, in order to materially ease the pressure on the VA, adequate funding must be provided to the States so that proposed projects may be completed.

Grants to the Republic of the Philippines

The budget message provides a grant of $500 thousand to the Veterans Memorial Hospital in Manila to replace and upgrade equipment and to rehabilitate the plant and facilities. This grant has been made by the United States consistently since the end of World War II. The Veterans Memorial Hospital cares for many Filipino veterans who served in the Allied cause during WWII. There is certainly an obligation by this country to continue to show our gratitude and concern for them. The American Legion continues its support for this grant.

CONSTRUCTION PROGRAMS

The budget proposal recommends a nominal increase in the VA's construction programs of close to $37 million, up to $525.7 million.

The VA construction program is now funded by three appropriations: Construction, Major Projects; Construction, Minor Projects; and the Parking Garage Revolving Fund.

The Construction, Major Projects appropriation provides for constructing, altering, extending and improving any VA facility, including planning, architectural and engineering services, and site acquisition, where the estimated cost of a project is $2 million or more, or where funds for a project were made available in a previous major project appropriation.

The Construction, Minor Projects appropriation provides for constructing, altering, extending and improving any VA facility, including the same services as with major construction, where the estimated cost of a project is less than $2 million, and for personnel and other expenses of the Office of Facilities.

The Parking Garage Revolving Fund provides for constructing, altering, or acquiring by purchase, lease, donation, exchange, or condemnation (including site acquisition), a parking facility or facilities for the accommodation of vehicles of employees of medical centers, visitors and other individuals having business at such facilities, or vehicles used to transport patients to and from the facilities.

According to the budget document, no money will be reprogrammed from the major working reserve in FY 1988.

Mr. Chairman, The American Legion wishes to commend the Administration for proposing an increase in medical construction. It is our opinion that it reflects the need for renovation and replacement projects within the system. However, we do have some concerns, which we shall enumerate in a moment.

Among the major medical construction projects for which funding has been requested in FY 1988 are a bed replacement and modernization at the Dayton, OH VA medical center; environmental improvements and patient and nursing home care buildings at the North Chicago, IL VA medical center; design of a new medical center in Palm Beach, FL; design of a clinical addition at the Atlanta, GA VA medical center; outpatient and ward renovations at the Montgomery, AL VA medical center; a replacement domiciliary in Prescott, AZ; a clinical improvement addition at the Huntington, WV VA medical center; and a clinical addition at the Jackson, MS VA medical center.

Also included is a request for $5.4 million to relocate the Wichita, KS regional office to the VA medical center grounds. The Veterans Administration is reviewing the colocation of various regional offices onto the site of the medical center nearest that facility. Future projects will be proposed wherever they are demonstrated to be cost-effective. The American Legion is supportive of the merging of regional office and medical center activities when it is advantageous to the veteran population that is served by the facilities.

It concerns The American Legion that there are no nursing home care units included in the projection for FY 1988. The only funds requested for nursing care are $4.5 million under minor construction for the conversion of hospital beds to nursing care beds, and for renovation of NHC wards to meet VA criteria standards.

During the FY 1987 budget process, The American Legion expressed its extreme concern about the Administration's "plan for the future" that dictated no new independent nursing home care unit construction, and greater reliance on State veteran homes and community nursing homes. While we have no quarrel with using community nursing homes where appropriate, and we certainly support the State veteran home program, we must again express our concerns over this issue. There are some veterans that because of their levels of disability, must be cared for in VA nursing home care units.

As for the replacement and renovation projects scheduled for FY 1988, based on the reports of our Field Representatives who make site visits to approximately 65 facilities per year, we can assure this Committee that all of the work scheduled is needed, and some of it is long overdue.

It is distressing to see that only two replacement hospitals are included in the FY 1988 projection. As we have stated in the past, the Office of Management and Budget is only fooling itself by delaying the funding for badly needed projects. Such a practice is false economy and will end up costing more in the long run, rather than saving the Government money, because the longer the projects are delayed the more it will cost to build them. Allowing the capital plant of the VA medical care system to deteriorate makes no sense at all and, in fact, contradicts the Administration's position on national defense when one considers that VA medical centers constitute the principal contingency resource to treat returning casualties during a war or national emergency.

With respect to the Parking Garage Revolving Fund, $4.1 million is requested for FY 1988, which is the exact amount needed to fund the Huntington, WV VAMC parking garage.

The collection of parking fees is required at each medical facility where funds from the revolving fund are expended for a garage constructed or acquired by the VA at a cost exceeding $500 thousand or, in the case of lease $100 thousand per year; or a project for the alteration of a garage at a cost exceeding $500 thousand. In addition, the Administrator at his discretion may establish parking fees at other VA hospital facilities. The VA is currently reviewing options to establish parking fees where appropriate. The American Legion has gone on notice in opposition to charging patients, visitors of patients, and hospital volunteers a parking fee.

DEPARTMENT OF MEMORIAL AFFAIRS

The proposed funding for the Department of Memorial Affairs reflects an increase of slightly over $3 million, up to $47.7 million. The projected average employment for FY 1988 is 1,187 which is a decrease of 2 FTEE.

The American Legion feels that the proposed funding for the Department of Memorial Affairs appears adequate. We totally support the construction program that is underway, and we continue to work with the Department in attempting to acquire land for the expansion of existing national cemeteries.

It is the perception of The American Legion that the total Memorial Affairs program is progressing in a satisfactory manner. We commend the progress that is being made, and trust that the Congress will continue to support VA's plans with the modest funding required to carry out this program.

VETERANS EMPLOYMENT AND TRAINING PROGRAMS

Mr. Chairman, as the Committee is well aware, in his presentation of The American Legion's legislative agenda last fall, National Commander James P. Dean cautioned that major changes in the nation's employment and training delivery system were expected to be proposed during the 100th Congress. Since the Federal Government's job and job training programs for veterans are largely integrated into these programs for the general public, such changes are likely to have a profound impact on veterans experiencing employment problems. Commander Dean urged the Veterans Affairs Committees to become active legislative participants as these proposals arose, and to give careful consideration to such budgetary proposals as the Administration may offer, which would aid and abet these anticipated changes.

Thus, before we discuss the Administration's budget proposals for veteran-specific employment and training programs, we would like to review the Administration's plans, either explicit or implied, for the nation's job programs as a whole.

There are two sections of the Administration's 1988 budget for the Department of Labor to which we wish to direct the Committee's attention:

First, the Administration is proposing to relinquish most Federal control over the financing of the administrative cost of the Unemployment Insurance system. As you probably know, the States have the taxing authority for revenues to pay such basic unemployment insurance benefits as State law mandates. The Federal Government however, pays for the basic administrative costs of the unemployment insurance system, i.e., personnel, office space, paperclips, etc. These costs are not borne by general revenue, however, but are paid for through a special Federal tax on employers, authorized by the Federal Unemployment Tax Act (FUTA). FUTA monies, however, also pay for the cost of operating the State Employment Security Agency (SESA) system. The Employment Service, according to chapters 41 and 42 of title 38, is the principal vehicle for the delivery of job services to veterans, and operates under a Federal mandate for veterans preference in delivery of its services.

The American Legion notes that the Department of Labor's budget talks vaguely about a "refocus of the Employment Service". We believe, however, that it is the Administration's intention to "defederalize" the financing of the Employment Service, along with the unemployment insurance system, since both are financed by the same revenue source. If that happens, Mr. Chairman, without the active oversight of this Committee, we believe that such services as may be prescribed for veterans under title 38 will vanish, since the Federal control necessary to assure their delivery will also have disappeared. The American Legion has some specific proposals for revisions in title 38 which will forestall these consequences at least in part, and we will be sharing them with the Committee in the next several weeks. Nevertheless, the problem needs to be examined in light of the proposed budget, and we urge you to express strong concern over this matter to your colleagues on the Budget Committee, as a part of your recommendations.

Second, the Labor Department's budget proposes a greatly invigorated effort to assist the nation's increasing numbers of dislocated workers. The Workers Adjustment Assistance Program (WAAP) will be funded in part by consolidation of funds for Title III of the Job Training Partnership Act (JTPA), and the Trade Adjustment Assistance Program. Altogether, the Administration is proposing nearly a billion dollars for the new program during FY 1988. Since the Labor Department's Bureau of Labor Statistics indicates that nearly 26% of all dislocated workers are veterans, The American Legion regards a concentrated national effort to assist these workers as a high economic priority. We must add, however, that the details of WAAP have not yet been released, and we must reserve our judgement on the merit of the program itself until we have had the opportunity to review it. During a recent meeting of the Secretary of Labor's Committee on Veterans Employment, we indicated to Secretary William Brock that given their high incidence among dislocated workers, we firmly believed that veterans ought to be a major target group in the program. Secretary Brock responded that he agreed.

We would now like to turn to the specific funding levels for veterans employment and training programs within the Department of Labor and the VA. Once again, we are pleased to note that the basic funding for the Office of the Assistant Secretary of Labor for Veterans Employment and Training appears to be adequate. Having acknowledged that, however, The American Legion notes that once again the Administration is attempting to reduce the number of Local Veterans Employment Representatives, while providing nominal full funding for the Disabled Veterans Outreach Program. Last year, you will remember, the Administration proposed the same type of reduction, and justified it based upon a change in regulations which the Labor Department had instituted that eliminated the traditional service area population requirement it had used for many years. This year, however, the Labor Department is proposing to reduce the number of LVERs required by its own amended regulations. It is clear that OMB has set an absolute budget mark for both programs, and subtracted from that the number of DVOPs required by title 38's statutory formula. The balance determines the number of LVER positions. Title 38, however, is explicit in requiring a waiver for a fulltime LVER based solely on determination of need, not OMB's mark. Last year, Congress agreed to fund 1,432 LVERs and restored nearly $8 million to the budget to do so. We urge this Committee to recommend a similar course to the Budget Committee for 1988.

Finally, we would like to turn to the Veterans Job Training Act (VJTA) program which, as this hearing is taking place, is shutting down throughout the nation due to lack of funds. The Committee is undoubtedly aware that it was not until nearly the end of last year when either the Department of Labor or the veterans service organizations had any inkling that VJTA funding was near depletion or that the VA, at the prodding of OMB, had allowed what will ultimately amount to $8 million to revert to Treasury. This continued lack of support by the Administration, and, surprisingly enough, by the VA itself, is the principal reason that no new or supplemental funding for the program appears anywhere within the new VA budget.

Last year, the Congress authorized the transfer of $35 million in minor construction funds to VJTA. The Administration even opposed this proposal, although it involved no new monies, on the grounds that the program had been slow to spend the original $150 million in appropriations. Now, with the contention that the program could not spend the $35 million (and hence was not needed) put to the lie, the Administration still refuses to provide any money to continue what has turned out to be a very successful job program. As the Committee knows, $30 million still remains from the original authorization, and in the Legion's view, should have been included in this budget, based upon the program's increasingly positive performance. We recommend that the new budget provide the additional $30 million in the 1987 supplemental. In addition Mr. Chairman, we look forward to working with you and the new Subcommittee Chairman, in reauthorizing VJTA until the end of 1991.

HOMELESS VETERANS

Mr. Chairman, last year the Subcommittee on Education, Training and Employment held hearings on homelessness among veterans. During the course of the hearing, the Subcommittee learned that while estimates of the extent of homelessness among veterans vary as they do for the population at large, 80,000 to 160,000 veterans are homeless on a given night - approximately one-third of the entire homeless population.

Last week the Senate passed H.J.Res. 102 which would provide $50 million in additional funds for assistance to the homeless. In the course of its deliberations, the Senate earmarked 10% of these funds to target homeless veterans. We urge you to encourage your colleagues to adopt this amendment in conference.

CONCLUSION

Mr. Chairman and Members of the Committee, in this statement we have set forth the positions of The American Legion on a variety of subjects that are included in the Budget Message of the Administration for the VA which we consider to be of special importance to the nation's veterans. We have spoken to those programs we believe to be of highest priority in an agency whose activities are all of high priority, because they are intended to respond to the needs, first of those who were disabled in war service, and then to the reasonable needs of all those who served honorably when called to do so by the nation.

As has been stated to this Committee on many occasions, it is the position of The American Legion that when the national priorities are established, funding for veterans programs should rightfully rank second only to national defense.

The proposed Veterans Administration budget for FY 1988 reflects an increase over the current fiscal year's funding, but it also contains some serious shortfalls. The fact is that veterans benefits and services, unlike most other domestic programs funded by the Federal Government, do not consume an increasing share of the Federal dollar.

Consistent and persistent staffing reductions in the Departments of Veterans Benefits and Medicine and Surgery are going to result in irreparable damage to the programs carried out under these Departments. The losses in DVB have caused innumerable problems in the regional offices and are adversely impacting on the quality and timeliness of the delivery of benefits and services to veterans.

The FTEE reductions in DM&S that are constantly chipping away at the number of health care professionals in the system are going to result in the erosion of the quality of medical care that is being provided this nation's veterans.

We endeavor to leave this Committtee with the understanding that The American Legion does not consider the Administration's request for funding of all programs administered by the Veterans Administration to be satisfactory. We have offered specific comment on those areas in which we feel there are the most glaring inadequacies, and we have addressed each of the legislative initiatives with respect to the concerns of this organization.

We trust the Committee will examine and consider the problem areas we have identified. As time and opportunity permit, we will be prepared and look forward to discussion and dialogue with the Committee about the various veterans programs that will be under consideration during this session of Congress.

Mr. Chairman, we appreciate this opportunity to present the views of The American Legion.

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Fiscal Year 1988 Budget

Statement

of

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Legislative Director

Vietnam Veterans of America

accompanied by

Richard F. Weidman
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and

Thomas A. Sherwood
Director of Health Policy and Planning

before the

House Veterans Affairs Committee

United States House of Representatives

February 4, 1987

INTRODUCTION

When the Fiscal Year 1988 budget for the VA was unveiled by the Administration it was heralded by VA officials as a budget which shifts and refocuses resources toward benefits and services for service connected disabled veterans. In our examination of the Administration's submission for 1988, we find very little reality behind the rhetoric.

At VVA we are often asked by the media, by capital hill staff and our own membership if the President's budget contains enough money for veterans programs and services. The point must be made once again that the amount of money is not the issue. How that money is spent is the essential, perhaps the only question to be answered. VVA's general position is that a VA budget of $27 billion is very adequate to fulfill the mission of that agency. At the same time we do not believe that a sufficient amount is being spent for vital services in the areas of service connected health care, rehabilitation and readjustment.

In addition to this budget failing to live up to its promise regarding a shift of priorities, we also see some significant failures in a fiscal management sense. The elimination of nearly 3000 positions in the Department of Medicine and Surgery can hardly be justified as claimed by better computerization and implementation of the means test. Nor will the "RAM" system provide an adequate guide as to exactly which positions should be eliminated.

We find, particularly in the area of health care, that this budget generally represents less of the same. This area under the president's budget represents a slightly scaled down version of what has always been a general health care system for veterans, rather than building towards a system of veterans' medical care.

In testimony before Congress in 1985 VVA called for a re-examination of the veterans benefits and services system along the lines of the Bradley Commission study of 30 years ago. VVA also urged fresh consideration of many of the conclusions and recommendations of that Commission. We believe now, more than ever, that our 1985 recommendations would provide much needed guidance in determining veterans budget priorities for 1988.

THE "INDEPENDENT BUDGET PROJECT" OF THE VETERANS SERVICE ORGANIZATIONS

Even though VVA was not involved in this project we feel it would be appropriate to make a few brief comments about this proposal. While we do see this Veterans Service Organization (VSO) joint submission of an alternative budget as a noteworthy event, and a number of suggestions contained in it are very worthy, VVA cannot endorse the proposal. We find regrettably, that for the following reasons, we do not agree with either the proposal as a whole nor do we approve of the general thrust;

1. This proposal's "more of the same" in that it appropriates more public dollars which appear to serve private interests more than the veteran. As an illustration, on page 32 of the VSO Budget there is a request for $9 million additional dollars and 200 FTEE for medical and dental residency positions at VA affiliated Medical Schools. We see no reason to assume that services to veterans would necessarily be enhanced or expanded as a result. We see no reason why the private Medical schools would not use the resources thus made free to expand their programs in other areas. Neither do we see how any proposal would enhance retention. This is a boon to the private interests of the Medical schools taken at the direct expense of the veteran.

2. We do not see it as our responsibility to to "manage" the VA via a separate budget proposal, as they have a large staff at 810 Vermont Avenue legally charged with that responsibility. It is however, absolutely essential that we are honestly and thoroughly informed of the budget, especially the VA's budget priorities.

3. VVA does recognize the VSO's effort for its commendable recommendation to reactivate the Health Professionals

Scholarship, which inadvertently recognizes the apparent on-coming shortage of Nurses. This shortage is primarily caused by the changing roles of women in this Country, and the feeling that nurses in the VA system do not have control over their practice. However, the VSO document, like the Administrations submitted proposal, clearly does not speak to forces of fundamental change which are essential if the VA hopes to emerge in the 21st Century with the magnified potential to better serve the veteran. These forces must include:

a. A Resource Allocation Methodology that is clear, greatly simplified, and is directly related to the actual cost per patient, per day, per diagnosis. Such a system must be one that both the Administrator for Veterans Affairs and the Service Chief at the Medical Center level can functionally understand and use to make rational, meaningful decisions as to the allocation of health care dollars to truly benefit patient care.

b. A management system which supports the providers of services to our veterans above a heavily centralized, politicized bureaucracy which attempts to drive the provider relative to VACO agendas instead of to the patient's need. While the VA heatedly denies it, VVA has strong indications that RAM management decisions increasingly distort and drive clinical decisions.

VVA does recognize the value in this first time combined effort of the AMVETS, DAV, PVA, and VFW. We as colleagues representing Vietnam veterans acknowledge the VSO's seeking our support, as we all work together with the Committees of Congress in the attempt to bring to those who have borne the battle the best health care possible.

HEALTH CARE

In view of the above we wish you to be aware of some of the vital issues of VA Health Care which concern VVA. In our approach to the FY 1988 Budget we are seeking assurance that the dollars spent are spent wisely. We are seeking assurance not only of adequate funding and cost effectiveness but of quality health care delivery. We need to be assured that:

1. Health care dollars and resources are directed primarily at direct "hands-on" care of the veteran and that the need for those dollars and resources are to be field-sponsored and directed (after given appropriate parameters for practice) and not centrally directed. The Resource Allocation Methodology (RAM) or other such Diagnostic Related Grouping (DRG) based resource allocating schemes of the Veterans Administration Central Office, which are said to be designed to determine costs for the care of the patient, appear to be subject to VACO constraints resulting in constant model "fixing", constant "readjustment" and constant confusion at the Medical Centers where patient care is delivered. Medical Center Directors have a limited ability to correct their losses (i.e. "beat the system of the RAM Game") because they do not control the allocation of resources to fit the needs of the veterans at their Medical Center. The VACO constraints appear to relate more to the politics of driving a large cumbersome centralizing system (top down) than to the consideration of the benefits of a bottom-up decentralization resource allocation methodology which takes into strong consideration the individual need of the patient as determined at the Medical Center level.

2. We need to be assured that the neuro-psychiatric patient receives a fair-share of the quality and quantity of care

as reflected in the VA health care budget. Forty percent of all VA inpatients are being treated for neuro-psychiatric illnesses, yet only nine percent of the VA health care budget is directed for their care. The "pull" of the medical teaching affiliation programs is towards acute medical and surgical care at the expense of both the neuro-psychiatric and long term care patients. Budget distortions in the name of research and education deny the clinical reality of the larger numbers of neuro-psychiatric and long term care patients now in the system. It is clear to VVA that the teaching affiliations are both necessary and important, and they do operate in the areas of long term care and psychiatry. Many of our veterans are multi-diagnostic in the sense that they can have neuro-psychiatric problems, medical problems and be elderly all at the same time. The issue here is: shall the clinical dynamics of our veterans dictate the resources required for appropriation or shall the centralizing administrative/political bureaucracy do it. We favor, as we believe this Congress and the American people do, consideration of the needs of the patient first. The VA may at least recognize the broad variability of psychiatric illness with more discrete DRGs and allocate resources to provide the necessary care.

3. We need to be assured that the service connected disabled veteran is not adversely affected by reduced health care through resource limitations induced by required budget cuts. We need to be assured that excessive treatment of non-service connected veterans, administrative staff engorgement, excessive bureaucratic programs, and high-powered administrative schemes of alleged management improvements, not directly assistive to the quality of patient care, do not take precedence over care for those who have been lessened in the service of their country. VVA is well aware of the importance of the non-service

connected veteran patient relative to the justification of teaching and research programs between the affiliating institutions and the VA Medical Centers. Indeed, if the VA treated only service connected veterans relative to its current budget it would be difficult to justify even minimally its existence in relation to its size. This factor alone provides a strong incentive for the VA to serve the non-service connected veteran but we insist this not be at the expense of the service connected disabled.

4. We need to be assured that the VA health care system is organized in a manner which gives the authority, responsibility and accountability for maximizing abilities and potential in the care of veterans to those who actually provide the direct services. The role of all staff above the Medical Center Director must be to provide the administrative support, systems support, resources, and ethical/integrative assistance needed as opposed to political interference and heavy-handed centralized management.

We were disappointed that a section of HR 4623 which called for a five hospital experiment in direct determination of resource allocation did not survive final passage. This project would help determine if VA Medical Center Directors can maintain or improve the quality of care by allocating resources independent of VACO total management. It is our belief that such a program of self-prioritizing based on local patient care needs rather than VACO needs would improve the quality of health care.

5. We need to be assured that the VA programs its health care delivery system away from the model of sickness, humiliation and dependency to one of wellness, illness prevention, independence and self reliance.

We are extremely concerned about plans to move the highly clinically and cost effective Vet Center programs into the Medical Center and its Out Patient Clinics - Mental Health or otherwise. These clinics often show little understanding of the PTSD patient and generally do not have the capacity to meet the patient's needs within the framework of a psychiatric model driven by the dominant DRG classification called psychosis. We are concerned about the loss of the veteran patient to a lower therapeutic level of psychiatric care which may be forced to pharmacologically "control" these patients denying them the opportunity to explore their disorder and resulting in decreased individual control and dignity. While such a system may desire to do better for these veterans, it is unable to because of the lack of medical political equality with medicine and surgery and the subsequent related resources that come from being less than main line.

6. The elimination of positions such as the 225 positions noted in the VA budget proposal for 1988 in Medical and Prosthetic Research is recommended with neither a clear rationale or understanding with regard to programmatic impact within a framework of overall health care delivery needs in the context of the finite resources available. What concerns VVA in this matter is that there seems to be a high degree of arbitrary caprice in this budget process. If one is not sure exactly where the almost 3,000 FTEE's are to be eliminated from DM&S how does anyone know that this is a "reasonable" proposal, as it is seemingly an unknown quantity as to what the effect will be.

7. In light of the requirement of the Administration to submit a report to the Committee not later than December 15, 1987 (pursuant to PL. 99-576) on the Administrator's current "use of authority to contract for care and treatment, and for rehabilitative services, for chronically mentally ill veterans through halfway houses, therapeutic

communities, and other community based treatment facilities," VVA needs to be assured that all such funds for FY '87 will in fact be used for the purposes which the Congress intended, and that no reduction of either requested or actual intended use of such funds in contemplated by the VA for FY '88. It is the view of Vietnam Veterans of America that any "savings" that are effected in this manner are illusory. These facilities, according to VA's internal studies, have led to significant reduction in the need for further, much more expensive, acute care for potential users of such programs. Not only is it potentially more expensive in fiscal terms, the human cost of veterans not assisted toward a positive productive role in our society, is significant and far outweighs any short term "savings."

8. VVA seeks assurance that resource needs are discreetly defined and acted upon in terms of the planning process with the patient in mind. For example, it should not be necessary to reduce the equipment budget by one half and terminate non-recurring maintenance dollars in order to direct those funds to the personnel services budget because for a given fiscal year there is not enough dollars to support the current personnel ceiling. Such a practice could interfere with the flow of much needed equipment and obstruct the continuity of the planning process.

EMPLOYMENT ISSUES

In regard to the Veterans Employment and Training Service (VETS) proposed budget of FY 88, Vietnam Veterans of America notes that while the proposed level of funding for the VETS personnel is fully funded for 279 positions and the Disabled Veterans Outreach Program (DVOP) is fully funded for 1,894 FTEE positions, there is a disturbing and unwarranted cut in the

Local Veteran Employment Representative (LVER) program. This decrease of approximately $5.4 million in the Administration's request would result in elimination of 170 to 180 positions nationwide. Vietnam Veterans of America takes exception to the Administration's assertion that this request "will support the legislatively mandated and administratively required positions" in these programs. VVA urges the committee to seek restoration of a funding level for LVERS that would maintain the current level of 1,379 FTEE.

In this regard, VVA believes that it is indisputable that viable employment is an integral component of readjustment. Over 40% of veterans seeking assistance at Vet Centers (VA Readjustment Counseling Outreach Centers) have significant difficulty with employment. Furthermore, over 450,000 veterans have been approved for participation in the Veterans Job Training Act since its inception, although only 50,000 (approximately) have been placed in jobs. The need is clear, so it is astonishing to VVA that the Administration has requested no funds to continue operation of the program which has been particularly useful as a tool to assist disabled and other long term unemployed Vietnam veterans to return to a productive role in the economic life of our nation. VVA urges the Committee to exercise the leadership necessary to ensure that this vital veterans readjustment program is continued with something approaching continuity.

Pursuant to the authority of Public Law 97-72, the U.S. Small Business Administration (SBA) has maintained a special direct loan fund for Vietnam Era Veterans, which last year was funded at a level of $19 million dollars. The Administration has proposed elimination of this program as part of the FY '88 Budget. Although SBA per se is outside the formal jurisdiction of the Committee on Veterans Affairs, this particular program was created by a law which originated in this Committee. VVA therefore urges the Committee to take up this matter to determine whether the need for this program has indeed diminished. We would point out that the SBA did in fact use all of the funds available in this program for business loans to qualified veterans.

VETERANS BENEFITS

A great deal of debate and discussion has taken place in regard to outreach by the VA in the past few years. VVA is keenly aware that denying veterans accurate information and knowledge of veterans benefits and services is tantamount to denying those vital services to veterans. The Congress has repeatedly recognized this in Title 38 by mandating VA to do adequate outreach and benefits counseling. Yet this proposed budget would only print 20,000 copies of the all but impossible to obtain, "IS-1" booklet entitled "Federal Benefits for Veterans and Dependents." Further, the VA indicated at the January budget briefing that as many as 75 of the 883 remaining "Veterans Benefits Counselors" (VBCs) position assigned to Regional Offices will be eliminated if the President's proposed budget is accepted. VVA and the Congress has been assured each of the last six years that the VA could adequately and properly do the job with fewer people, as the number of these positions were cut by 40% over the last seven years. However, we are asked to be "understanding" that there are not enough VBCs to answer the "Hotline" telephones at VA Regional Offices, much less do outreach to veterans in shelters for the homeless, or to other veterans in acute need of vital assistance.

VA HOME LOAN GUARANTY

In regard to the VA Home Loan Guaranty Program, Vietnam Veterans of America is dismayed that the Administration is seemingly continuing its six year effort to undermine this vital veterans readjustment program. VVA would note that the Administration has signaled its intent in the proposed Budget document to proceed with the sale of $300 million of its loan portfolio, and to make all such sales "without recourse." VVA would point out that the General Accounting Office (GAO) has deemed this proposal to be unwise in its long term return to the government. In essence, the Administration is proposing a "fire sale". GAO stated that OMB's policies in this regard "will result in program objectives not being fully achieved." (GAO/AFMD-86-79; "Loan Asset Sales"; September 25, 1986.) VVA endorses GAO's prudent recommendation that the VA sell loans on a "structured basis, which would include some form of future recourse to the government."

The Administration proposal to have "a lender/borrower negotiated GI interest rate" would clearly result, in almost all cases, in a higher rate paid by veterans, especially those low and moderate income veterans dependent upon a no-or-minimum down payment loan. Further, there is a cogent school of thought that the rate set by the VA is a leading indication of rates on loans and helps dampen tendencies toward inflation in the mortgage market.

VVA has serious questions about the continuance of the methodology used in determining whether or not to acquire a VA guaranteed property in foreclosure. Not acquiring a property, the so-called "no bid" situation is now 15%, and rapidly growing. This jeopardizes future loans, especially "no down payment loans," and if this shift continues at the current rate, will result in the demise of the program as it has operated successfully for over 40 years.

VVA opposes the Administrations proposed increase funding fee from 1 percent to 2.5 percent as it is clearly nothing other than an unwarranted tax increase on veterans, which will further weaken this vital program for those veterans of moderate income seeking to enter the housing market for the first time.

STATE HOMES

Vietnam Veterans of America (VVA) supports the Administration's request for at least $42 million for grants for Construction of State Extended Care Facilities. This is the kind of creative leveraging of non-Federal dollars that makes a great deal of sense to VVA, and which we would encourage. Finally, if the nation is to be able to adequately deal with the large numbers of aging veterans in a proper and decent manner, VVA believes that an additional pool of grant funds should be created, that would make similar grants to the states, but on a competitive basis, with a view toward funding construction of facilities with multiple levels of care that are designed to assist and promote veterans in living as independently as possible. A fund of $10 to $15 million should be adequate to test this concept. In order to be able to provide more than "warehousing" levels of care, VVA also supports an increase in the per diem reimbursed to the states for care in state home facilities.

CONCLUSION

In summary, VVA finds that we are unable to support a budget which represents less of the same configuration of resources for veterans programs and services. Neither can we support the alternative budget presented jointly by four other veterans organizations as it appears to be, although an significant effort, only more of the same.

Wherever cuts or enhancements are made in the budget battle in the coming months, VVA asks that the overall resource allocation scheme make sense. We ask that a clear and definite priority be given to care and services for the service connected disabled, rehabilitative and readjustment programs. We ask that resource allocation decisions be made based on a system that is driven by patient needs. We also ask that any budget adjustments be made in consideration of overall program integrity.

The Constitution of Vietnam Veterans of America states that military service is an obligation of citizenship. A corollary of that principle is that veterans status should not be viewed as an entitlement to privileged treatment in American society. Another is that society has a corresponding obligation to provide prompt and effective benefits and services to those who were lessened by that service so that as nearly as possible they may achieve par status with those who did not serve.

The Bradley Commission Report of the 1950s was not the only prestigious body to recommend a refocus of priorities in the direction of those who paid the highest price for service. In 1974 the Twentieth Century Fund convened a task force chaired by former HEW Secretary Robert Finch and among whose members were Robert Ball, former Social Security Commissioner and William Driver, former VA Administrator. Their report in part reads:

"Present eligibility standards for veterans' benefits indiscriminately give preferential governmental assistance both to individuals who sacrificed literally everything by war-related total disability and to those who sacrificed little or nothing and left the service without any handicaps. Any rationale for veterans benefits based on sacrifice or handicaps of service would in principle call for more discrimination in benefits based on actual individual experience."

VVA asks that this principle be foremost as guidance in your budget deliberations this year.

Mr. Chairman, members of the Committee, that concludes our testimony on the FY 1988 veterans affairs budget. We appreciate very much the opportunity to appear before you on this important issue.

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February 12, 1987

Ms. E. Elaine Lloyd, President
Nurses Association of the
Veterans' Administration
505 E. Hawley Street
Mundelein, IL 60060

Dear Ms. Lloyd:

Thank you for forwarding the testimony of NOVA for inclusion in the Committee's hearing on the fiscal year 1988 VA budget.

Your testimony will be be made a part of the hearing record and I am forwarding a copy to the Chief Medical Director of the VA for his information.

Sincerely yours,

G. V. (SONNY) MONTGOMERY
Chairman

cc: Dr. John Gronvall

GVM:mbd

STATEMENT SUBMITTED FOR THE RECORD

E. ELAINE LLOYD, MS, RN, CS

PRESIDENT, NURSES ORGANIZATION OF THE VETERANS' ADMINISTRATION

(NOVA)

February 4, 1987

Committee on Veterans' Affairs Hearing on the

Fiscal Year 1988 VA Budget

Mr. Chairman and Members of the Subcommittee, I am E. Elaine Lloyd, a Registered Nurse employed full-time as a Clinical Nurse Specialist at the Spinal Cord Injury Center, Veterans Administration Medical Center, Palo Alto, California. I am here today as President of the Nurses Organization of the Veterans Administration (NOVA) and I thank the Committee for the opportunity to appear before you. While I speak as the representative of NOVA, it is my goal to address the needs of the veteran patients cared for by over 32,000 RNs in the 172 VA Hospitals and 200 outpatient clinics. NOVA is most concerned about the adverse effect on veteran health care of the proposed 1988 VA Medical Budget and the 1987 budget rescission request.

The Administration's proposed budget, including the 75 million dollars rescinded from our current health care budget and more for the FY 1988 budget is unthinkable to those Registered Nurses working and caring for patients.

When a reduction in 212,000 outpatient visits is talked about in Washington, what that means to us in the hospitals and clinics is further delays in scheduling patients for the follow up clinic appointments they need.

For example, when a patient leaves the hospital on a new medication, he is often given a 30 day supply of medicine and a request from his treating doctor for an appointment in one month to review the effectiveness of treatment, development of side effects, need for change in dosage or medication, or a renewal of the prescription. Overcrowding in the outpatient clinics means the patient can't be scheduled for this appointment on time and the renewal of medications becomes an urgent problem for the patient who then may wind up in the emergency room--certainly a more expensive way of treating him.

When a reduction of 15,600 inpatients is proposed it may mean that veterans in need of hospitalization become sicker as they wait for admission. When needed medical or psychiatric treatment is delayed, the hospital stay may be prolonged or the rehabilitation less effective due to additional problems or complications arising during the delay.

When decreases in FTEE and increases in productivity are proposed, what that means to Registered Nurses giving care in the field is that we are exhorted "to do more with less." With the historic low staff to patient ratios in the Veterans Administration Hospitals, nurses are already running at full speed.

Intravenous bottles and wound dressings can only be changed so quickly, basics such as turning a patient who cannot or does not move unaided or feeding a patient requires nursing time. Patients can only learn to care for their colostomy or give their own insulin or be weaned from a ventilator at a pace that is safe. As nurses we feel the veteran patient will get less with less.

The VA is currently not staffing to its own staffing methodology guidelines. Current data indicates the VA is 8,200 nurses short of what's required to operate the system.

When NOVA looks at a loss of 3,000 health care employees in the remainder of 1987 and thousands more in FY 88 we see a further erosion in the care nurses are able to provide to patients.

Even when the losses in personnel are not nurses, the veteran is deprived of medical and nursing care. For example, when laboratory personnel cannot answer their phone until 11 a.m. due to personnel shortages, the physician and nurse are deprived of prompt information to treat the patient; when pharmacy personnel are not available to deliver medications the patient is deprived of nurses time when the nurse must leave the patient care area to go to the pharmacy. As support services decline, again nurses are asked "to do more with less."

Any proposed reduction in nursing staff is unthinkable when NOVA members throughout the country report acute shortages of both RNs and LPNs in their own VA Hospitals.

Vacancies range from 30-80 licensed nursing positions across the country with the metropolitan areas on both coasts most severely affected. The nationwide average time to fill an RN vacancy is 60 days in the private sector. These shortages of nurses place the veteran at risk for a longer hospital stay, developing complications such as pneumonia or pressure sores or discharge without adequate preparation and teaching. Teaching that would help him understand how to care for himself or how and why he must take his medication or follow his treatment regime. Registered nurses are the constants in the hospital--we are there 24 hours every day and seven days a week. We are the observers, the monitors, the teachers, the clinicians who collaborate with the physician and other health care professionals in the care and treatment of hospitalized veterans.

As the shortage of nurses in VA Hospitals increases, the patient/nurse ratio increases. Nurses are asked to work overtime and doubleshifts. Studies have shown over half of VA nurses work overtime about once a week. Overtime pay creates havoc with the budget. Nurses are further stressed when asked to work multiple shifts in the same week to fill in the gaps. All of the above compounds the retention problem and VA nurses are lured to the private sector which can offer more stable work schedules, better patient/nurse ratios, higher salaries and better fringe benefits including tuition reimbursement.

The solution to these shortages is not forthcoming because the VA is not competitive in recruiting RNs in the midst of a national shortage of nurses. The shortage today is caused in part by a decreased enrollment in schools of nursing. Some schools report as much as a 30% drop in enrollment with the national average decline approximately 10%. Hospitals lose nurses to expanding programs of home care, free standing clinics, and same-day surgery.

Shortages are nothing new. The widespread nursing shortages of the late 1970s and early 1980s had a severe impact on staffing in the VA Medical Centers. In August 1980 PL 96-330 called for the VA to conduct pilot programs and a study of actions that would enable the VA to recruit and retain sufficient qualified nursing personnel. 9,000 VA nurses responded to the survey--an overwhelming response. The data derived from the study supported the results of smaller studies made in the 1960s and 1970s in which demanding work schedules, inadequate staffing and a lack of opportunity for continuing education were seen as causes for dissatifaction. Fortunately for the Congress and the VA, further study is not required at this time. The recommendations from the earlier study hold true today.

For your review I submit the fifteen recommendations emanating from the 1981 study:

1. Special salary rates and various pay options as provided for by PL 96-330 and PL 97-251 to enhance recruitment and retention should be monitored and adjusted in accordance with established criteria to assure that pay rates are competitive with but do not exceed the community rates.

2. Nurse staffing levels must be established and maintained in accordance with standards based on reliable measurements of workload.

3. Mechanisms must be provided to reduce job-related stress for nursing personnel.

4. The use of flexible work schedules, as provided for by PL 97-221 should be encouraged.

5. Support services must be consistently provided by personnel other than physicians and nursing staff.

6. Automated data processing should be utilized for applicable clinical and administrative functions.

7. Nurses' work assignments should be stabilized to minimize temporary reassignments to other patient care units.

8. Staffing patterns should be developed to eliminate rotation to different tours of duty.

9. Flexible work schedules should assure nursing personnel of every other weekend off duty.

10. Recruitment and retention of licensed practical/vocational nurses should be stressed, in accordance with provisions of PL 98-160.

11. Tuition reimbursement should be offered to all nurses enrolled in courses which enhance their work.

12. Upward mobility programs for employees seeking nursing careers should be given additional monetary support.

13. Child care centers should only be considered if such a need is demonstrated since findings did not reveal that it was a major factor in recruitment and retention of nurses.

14. Funding for innovative projects to enhance recruitment and retention should be provided.

15. A national recognition program for nursing employees should be implemented.

Of these 15 recommendations modest gains have been made in many hospitals to minimize floating to other patient care units, and the national recognition program for nursing employees has been implemented. But these modest gains do not correct the real problems of recruitment and retention of nurses. To stop the hemorrhage of nurses from the VA and save the VA health care system there are three critical steps that can be taken.

Salaries

The Special salary rates for RNs in effect in approximately 92 Medical Centers need to be budgeted and funded. The Medical Centers must be able to respond quickly to a changing market-place. Assuring that nurses on special salary rates also receive the Federal Employee Cost of Living Adjustment would help prevent the severe discrepancies between the VA and the private sector.

Tuition Reimbursement

A program of tuition reimbursement for VA staff to receive education and training while employed would help the VA compete with the private sector. The 1985 American Hospital Association Survey found 70% of the hospitals surveyed paid tuition reimbursement.

Staffing

Any cuts in VA health care personnel must be opposed with vigor and steps must be taken to increase nursing staff to meet the increased workloads. There are staffing methods and methodologies to guide us to realistic workloads and they should be used.

NOVA requests this action on behalf of the competent and caring professional nurses working in the VA system who wish to continue with the mission of providing "care that will assist veterans in maintaining or regaining health, learning to live with disabilities, or dying with dignity and comfort."

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

MAR 12 1987

In Reply Refer To:

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed are the responses to the questions for the hearing record submitted by you and Representatives Gerald Solomon, Wayne Dowdy, Lane Evans, Marcy Kaptur, Timothy Penny, Paul Kanjorski, and Bob Dornan on February 12, 1987.

Thank you for your understanding concerning the amount of time required for completion of our concurrence process and extending the due date for our responses. Please let me know if we can be of further assistance.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosures

"America is #1—Thanks to our Veterans"

Chairman Montgomery to VA

CHAIRMAN MONTGOMERY

Question: 1. There have been a number of criticisms of the RAM model. Among them is that medical centers are unable to verify the data used in the modelling for their medical center. That is, if a medical center is a "loser" it is unable to ensure that accurate data were used as input. What is being done to improve this situation?

Answer: Data validation is a critical issue requiring continuous attention at the VA Medical Center, Regional, and VACO levels if the Resource Allocation Methodology (RAM) process is to be credible and viable. Last year, a number of "after the fact" adjustments were made before the final target allowance RAM calculations due to AMIS-PTF discrepancies affecting either inpatient and outpatient data or both from some of the VA Medical Centers. Due to these reconciliation problems and outcomes of the data in the past, several steps are being taken to improve this situation.

First, prior to a final computation of the RAM adjustment for the FY 1988 Target Allowance process, certification and verification of the FY 1986 data base to be used will be required at all three levels (VAMC, Regional, and VACO National) for all reported expenditures and workloads to be calculated.

Secondly, on-going monitoring is already being improved through use of the PTF 401 generated by the Austin Data Processing Center; local monitoring of AMIS-PTF discrepancies at the VAMC level on a monthly basis; and monitoring at all three levels will be assisted by the addition of several staff at both the Austin Data Processing Center and the Boston Development Center with data validation as a key responsibility. The Department will continue to study the issue of data validation, taking steps to strengthen the validation process at all levels.

Question: 2. It has been suggested that each stop in an outpatient visit be counted separately and weighted separately in the RAM model, rather than trying to aggregate several stops into one visit. Has this been suggested and what has been the response?

Answer: Counting and weighting outpatient clinic stops separately in the RAM model has been suggested. In the early stages of developing the outpatient RAM model, the possibility of costing and funding each clinic stop was debated at the technical and policy levels in DM&S. Technically, the costs and workloads could have been accumulated at the stop level, but the reporting burden was seen as monumental. From a policy perspective, the outcome would have been the encouragement of more clinic stops. Facilities with more clinic stops, regardless of types of patients, would have received more funding than they now receive under a patient-oriented model. A clinic stop based model would fund clinic stops rather than patients, would be driven by structural characteristics of facilities rather than types of patients. A clinic stop based model would provide incentives to create more clinics and keep all clinics "full", much as would be the case if the inpatient RAMs funded bed days of care rather than types of patients. The Department of Medicine and Surgery continues to be committed to using RAM models that are sensitive to patient resource requirements, and the current outpatient RAM reflects that commitment.

CHAIRMAN MONTGOMERY

Question: 3. How are the costs involved in sharing agreements treated under the RAM model?

Answer: The RAM does not differentiate between sharing agreements and other expenditures. However, the RCS 10-0141 (Cost Distribution Report), which provides cost data for RAM calculations, does distinguish between sharing agreements which do produce measurable RAM workload and those which do not. If measurable workload is performed at and by the VAMC and the work reported and costs expended constitute direct "hands on" care, they are reported under the 200 series accounts of the RCS 10-0141 and therefore included under the model. Sharing agreements which do not produce RAM measurable workload, on the other hand, are treated as "pass through" accounts and therefore not measured under the model.

Question: 4. How are DRG's related to AIDS and ARC (AIDS related complex) addressed in the RAM modelling?

Answer: The DRG system presently used does not specifically identify AIDS and ARC patients per se due to the fact that these patients presently fall into a number of DRGs and are funded for the costs in treatment of those DRGs. In the FY 1987 data base, use of the ICD 9-CM diagnosis manual (official for US) will allow for a more precise identification of AIDS and ARC patients - this will result in a larger number of these patients being reported.

Question: 5. Do the weighted work units accurately reflect the additional time and costs associated with the DRG's for AIDS?

Answer: Under the present DRG system, the additional time and costs associated with AIDS and ARC patients are not an accurate reflection of the additional time and costs associated with their treatment. Current costs for treating these patients is being investigated by the Department through a survey of VAMCs including appropriate VAMCs in New York, Miami, San Francisco, and Cleveland to estimate both inpatient and outpatient costs of treatment. To date, calculated estimates of these costs indicate that current funding appears to provide insufficient resources to centers experiencing a higher probable volume of these patients. Based on survey estimated findings, some key centers have received and will continue to receive additional funding supplements when possible within existing resources.

Question: 6. I understand that the data base year of 1985 is still being used to calculate target allowances for medical centers. Is that correct?

Answer: No, the FY 1985 data base is not still being used. We are currently in the process of preparing for the FY 1988 Target Allowance process. The FY 1986 data base will be used for the RAM calculated adjustment to the FY 1988 Target Allowance.

Question: 7. Since the experience of medical centers has been to improve and refine their record-keeping, FY 1986 data might be better used for 1988 target allowances. Can this be done? If not, why?

Answer: Yes, the FY 1986 data will be used to calculate the FY 1988 target allowances.

CHAIRMAN MONTGOMERY

Question: 8. Since Alaska and Hawaii have no VA facilities, please report on the implementation of procedures and experience so far under Public Law 99-272.

Answer: The "means test" procedures have been implemented in Alaska and Hawaii. For the 1st quarter FY 1987, 3,583 applications for care were received from veterans residing in Alaska. The percentage of Category A veterans is 70%, Category B is 8%, and Category C veterans is 21%. Alaska experiences a higher percentage of Category C veterans due to overall higher incomes earned in Alaska.

For the 1st quarter FY 1987, 1,297 applications for care were received from veterans residing in Hawaii. The percentage of Category A veterans is 93%, Category B veterans is 6% and Category C veterans is less than 1%.

Question: 9. In April of last year, the VA Inspector General recommended changes in the way that VA medical programs were administered in Alaska which would save $31.7 million a year. However, information presented with the budget indicates that obligations for this activity will rise from $33.7 million in 1986 to almost $36 million in 1988. Can you reconcile your budget proposal with the Inspector General's policy recommendations and claimed savings?

Answer: The absence of a DM&S clinic and/or VA medical center has created a unique situation whereby VA health care requirements are furnished through private providers with the VA involvement limited to authorization and payment of billings. This system provided only a limited opportunity for VA control of health care.

Negotiations, in October 1986, with the two main private hospitals in Anchorage resulted in informal pricing agreements, which are projected to reduce inpatient care costs by $2 million per year. Other administrative controls have been implemented which will reduce costs and enhance the applicant screening process. Further negotiations will be conducted with the goal of reducing the cost of Fee Basis physician services.

Based on the growing costs at the Anchorage facility, and the need for closer administrative control of clinical matters, the Administrator approved the establishment of a full-service DM&S Outpatient Clinic and authorized the positions of DM&S Clinic Director and Chief of Staff.

Rather than decline, the budgeted contract hospital expenditures remain relatively consistent through FY 1988, based on the projected activation schedule for the full-service outpatient clinic, which is expected to take approximately 18 months and will not be ready before 1989. Once the clinic is functioning, all Anchorage veterans would be initially seen at the VA clinic for treatment or referral, as appropriate. This 'gatekeeper' function would allow VA physicians to control referrals to inpatient care at Elmendorf AFB and/or utilize community resources. Contract hospital expenditures would be reduced through increased referrals to Elmendorf AFB Hospital under a VA/DOD sharing agreement for inpatient care.

The increase in contract hospital expenditures from FY 1986 to FY 1988 is based on the increased costs of inpatient care in the private sector with only a very minor change in program direction. The savings in the contract hospital program for FY 1989, after establishment of an outpatient clinic, depends largely on the ability of Elmendorf Air Force Base Hospital to absorb increased inpatient workload. Discussions with local Air Force officials are continuing at this time.

CHAIRMAN MONTGOMERY

Question: 10. Your budget submission recommends that we increase spending for non-VA hospital care from a level of $161 million in 1986 to almost $192 million in 1988--a 19% increase. Since the VA issued a report last year which generally found VA care to be less expensive than care furnished by the private sector, why wouldn't you try to find a way to treat fewer patients in non-VA facilities?

Answer: As a general rule, admission to a non-VA hospital at VA expense is limited to eligible service-connected veterans, in medically emergent circumstances, when VA or other Government facilities are unavailable. The greatest majority of these admissions occur under conditions beyond any control by the Agency. More often than not the veteran is already hospitalized when notification about a particular admission is made to the Veterans Administration. The requested increase reflects the actual rise in costs of administering the contract hospitalization program. We make every effort to move the veteran to a VA medical center as soon as the private, attending physician will agree to a release. Since we are unable to negotiate hospital and physician fees in advance, overall costs are difficult to control. The rate of increase between 1987 and the 1988 requested level is consistent with the cost experience for the past several years, which the Agency considers largely an uncontrollable cost.

Question: 11. The President's budget message transmitted to the Congress on January 5 claimed that the VA and the Department of Defense were provided an additional $100 million for AIDS treatment and blood screening. Did the VA in fact receive a single additional dollar for treatment of veterans who have AIDS? If so, where are these funds mentioned in the VA's budget documents?

Answer: The word "additional" is used in the President's budget message to refer to treatment funding, over and above the half billion dollars requested for several agencies in the entire 1986 Budget for AIDS research and education. The increase for VA treatment funding is derived from the current appropriation levels in Medical care. Facilities will manage their existing resource base to properly care for high priority veterans including those veterans with AIDS.

CHAIRMAN MONTGOMERY

Question: 12. Over the past 15 years, the VA has eliminated over 3,000 domiciliary beds and almost 10,500 psychiatric beds. Can you assess how this historical decline in the number of domiciliary and psychiatric beds operated by the VA has contributed to this increase in the population of homeless veterans? What is the monthly cost of maintaining a patient in a VA domiciliary bed?

Answer: The extent of the increase in the population of homeless veterans is of great concern to the VA. Outreach initiatives currently underway and others being planned, will help in determining the size of this cohort of veterans who are among the homeless, as well as the nature of their social, medical, economic, and psychological difficulties.

Despite the significant reduction in total psychiatric beds over the past 15 years, the number of VA-provided hospital treatment episodes for principle diagnoses of psychiatric disorders has not decreased significantly. During FY 1971 the total number of discharges from psychiatry service beds for psychiatric disorders was 166,789; during FY 1986 there were 178,911 such discharges. In addition, a special survey of the discharges from the intermediate medicine service with principle diagnosis of a psychiatric disorder was 14,223 in FY 1984; 17,326 in FY 1985; and 21,807 in FY 1986.

In summary, there are no persuasive data that the reduction in psychiatry service beds has been associated with decreased opportunities for needed inpatient care. Notwithstanding the absence of those data, it is likely that initiatives for shorter lengths of stay in hospital have required special vigilance and discharge planning to prevent the premature discharge of patients without resources.

The reductions in the number of VA Domiciliary Care Program beds have been made in response to decreases in the number of applications for domiciliary care and corresponding decreases in average daily occupancy rates. The VA Domiciliary Care Program is currently operating at 85% occupancy. It is doubtful that domiciliary bed reductions have caused an increase in the number of homeless veterans. Current domiciliary care costs range from $33.07 to $71.81 per day depending upon geographic location. Nation-wide, the average cost per day of care is $44.75.

HON. WAYNE DOWDY TO VA

CONGRESSMAN WAYNE DOWDY

QUESTION 1: According to the VA's FY 87 Budget, spending for Payments to States" in FY 87 was projected to be $9.8 million. The VA's FY 88 Budget estimates FY 87 spending at $9.3 million. I have been led to believe the $500,000 difference represents reprogramming within the Department of Veterans' Benefits (DVB) to accommodate personnel salary increase.

QUESTION 1a: Is that the case?

RESPONSE 1a: The $9.3 estimate for "Payments to States" is the current estimate. The Department of Veterans Benefits 1987 estimate includes a January 1987 pay raise, which was absorbed. The estimates made in the FY 1987 budget process were reassessed to determine the current year requirements and determine where the increased costs could be absored with little impact on service to the veteran. The change in Payment to States was one of these reassessments.

QUESTION 1b: Have other DVB budgetary items been reduced by a similar 5% to accommodate personnel salary increases?

RESPONSE 1b: The adjustments to other objects in the DVB budget are shown below. The adjustments were made in areas which will have little, if any, adverse effect on the delivery of benefits to veterans. The percentages listed show the difference between the SAA adjustment and others.

Revision of 1987 Budget

	Dollars	Percentage
Payroll	$1,486,000	.8
Travel	500,000	13.2
Printing	679,000	14.5
Supplies	300,000	5.3
Modernization	3,000,000	12.0
Equipment	1,115,000	16.2
Common Service	120,000	2.0
	$7,200,000	

QUESTION 1c: When were SAAs notified of the proposed reprogramming?

RESPONSE 1c: On January 14, 1987, the President and the Vice President of the National Association of State Approving Agencies (NASAA) met with VA officials. At this meeting, NASAA officials were informed of the agency's decision and the impact on State Approving Agencies (SAA) funding. In addition, VA officials also explained how the decision was made.

QUESTION 1d: SAAs have signed contracts with the VA for FY 87. Will this reduction cause the VA to fail to meet its contractual obligations to States in FY 87?

RESPONSE 1d: No.

HONORABLE WAYNE DOWDY

QUESTION 2: According to the VA's FY 1987 Budget, actual spending for "Payments to States" in FY 1985 was $11.7 million. The VA proposes to spend $8.4, a 28% cut in this account between FY 1985 and FY 1988. The VA's FY 1988 Budget document (General Operating Expenses Programs, Volume IV, pages 21-24) says the decline in spending "reflects an anticipated decrease in approvals and supervisory visits consistent with the recent declines in workload."

QUESTION 2A: Please provide me a breakdown of program participation (Chapters 30, 31, 32, 34, 35 of Title 38, and Chapter 106 of Title 10) for Fiscal Years 1985-88.

RESPONSE 2A: Attachment A provides the requested program participation data. The data for FYs 1987 and 1988 are estimates.

QUESTION 2B: Please provide me the number of participating institutions and training establishments (Chapters 30, 31, 32, 34, 35 of Chapter 38, and 106 of Title 10) for Fiscal Years 1985-88.

RESPONSE 2B: Attachments B-1 through B-4 provide data on the number of educational institutions and training establishments which have a veteran or eligible person enrolled and receiving Chapter 34 or 35 benefits at the end of the month. The data for the months February 1987 through September 1988 are estimates. The data show a marked decline in the total number of educational institutions (33% from October 1984 to present). We anticipate that this trend will continue and that there will be a 38% reduction in the number of institutions between FY 1985 and 1988. At present we do not have management reports which provide similar data for Chapters 32, 30 and 106. Specifications for a consolidated report for all Chapters have been developed and will be implemented in the future. It is our belief that most Chapter 32, 30 and 106 trainees will not create additional work for the states as they are or will be enrolled in institutions which also have Chapter 34 and 35 trainees and that the number of institutions which have only Chapter 32, 30 and 106 trainees is small. It should also be noted that programs for Chapter 31 trainees are approved by the VA, not the State approving agencies.

Attachment A

PROGRAM PARTICIPATION

Fiscal Year	1985	1986	1987	1988
Ch. 30	0	1	800	19,400
Ch. 31	26,901	25,776	25,000	24,500
Ch. 32	48,110	63,221	71,200	74,000
Ch. 34	402,281	307,637	233,600	182,900
Ch. 35	61,958	54,233	48,400	43,300
Ch. 106	1,160	31,678	87,800	123,600

Attachment B-1

FISCAL YEAR 1985	IHL	NCD	OJT	TOTAL
October 1984	4,173	2,675	4,471	11,319
November	4,253	2,687	4,415	11,355
December	3,809	2,656	4,451	10,916
January 1985	4,015	2,489	3,997	10,501
February	4,301	2,497	3,933	10,731
March	4,227	2,508	3,743	10,478
April	4,225	2,544	3,690	10,459
May	3,124	2,349	3,651	9,124
June	2,991	1,940	3,516	8,447
July	2,976	1,906	3,415	8,297
August	2,650	1,886	3,428	7,964
September	3,848	2,059	3,370	9,277

Attachment B-2

FISCAL YEAR 1986	IHL	NCD	OJT	TOTAL
October 1985	4,048	2,241	3,298	9,587
November	4,154	2,291	3,222	9,667
December	3,574	2,203	3,176	8,953
January 1986	3,909	2,182	3,070	9,161
February	4,183	2,217	3,023	9,423
March	4,050	2,162	2,939	9,151
April	4,010	2,139	2,920	9,069
May	2,841	1,943	2,896	7,680
June	2,820	1,674	2,836	7,330
July	2,880	1,602	2,653	7,135
August	2,335	1,577	2,523	6,435
September	3,642	1,822	2,430	7,894

IHL = Institution of Higher Learning
NCD = Non-College Degree Program
OJT = On-the-Job Training

Attachment B-3

FISCAL YEAR 1987	IHL	NCD	OJT	TOTAL
October 1986	3,837	1,900	2,327	8,064
November	not available			
December	3,414	1,859	2,296	7,569
January 1987	3,690	1,826	2,225	7,741
February	4,070	1,969	2,325	8,364
March	3,880	1,864	2,307	8,051
April	3,805	1,799	2,310	7,914
May	2,582	1,607	2,297	6,486
June	2,659	1,445	2,289	6,393
July	2,788	1,347	2,061	6,196
August	2,057	1,302	1,857	5,216
September	3,445	1,612	1,752	6,809

Attachment B-4

FISCAL YEAR 1988	IHL	NCD	OJT	TOTAL
October 1987	3,680	1,602	1,680	6,962
November	not available			
December	3,233	1,556	1,651	6,440
January 1988	3,539	1,565	1,662	6,766
February	3,960	1,748	1,788	7,496
March	3,717	1,606	1,811	7,134
April	3,611	1,513	1,827	6,951
May	2,347	1,329	1,821	5,497
June	2,508	1,247	1,847	5,602
July	2,699	1,133	1,602	5,434
August	1,813	1,075	1,367	4,255
September	3,259	1,427	1,263	5,949

IHL = Institution of Higher Learning
NCD = Non-College Degree Program
OJT = On-the-Job Training

HONORABLE WAYNE DOWDY

QUESTION 3:	On January 23, 1987, Donald Sweeney, President of the National Association of State Approving Agencies, wrote the Administrator regarding proposed FY 1987 and 1988 reductions in SAA funding. Please provide me with a copy of the Administrator's response and any supporting documents.
RESPONSE 3:	Attached is a copy of the Administrator's response to Mr. Sweeney's letter concerning reductions in funding for State approving agencies in FY's 1987 and 1988.

MAR 13 1987

Mr. C. Donald Sweeney
President
National Association of State
  Approving Agencies
Maine Department of Educational
  and Cultural Services
State House Station #23
Augusta, ME 04333

Dear Mr. Sweeney:

This is in reply to your recent letters concerning funding for State approving agencies in FYs 1987 and 1988.

In December 1986, the Veterans Administration absorbed unanticipated increased costs for FY 1987. Each Department reviewed their operating budgets to identify accounts which could be reduced to help offset the increased costs. The Department of Veterans Benefits reduced payments to State approving agencies as well as funds for travel, printing, supplies, equipment, and modernization. State approving agency payments were reduced 5.1 percent while the Department's travel was reduced 13.2 percent, printing 14.5 percent, supplies 5.3 percent, equipment 16.2 percent, and modernization 12 percent.

Definitive cost-reimbursement contracts were not offered prior to the start of FY 1987 because of the uncertainty associated with the funds available for State approving agency activities. State approving agencies were informed that the proposed funds allocated for FY 1987 were subject to change. In the event that funding might change, Letter Contracts were issued limiting the amount of money to be spent and reimbursed and the Veterans Administration's liability. Therefore, the subsequent adjustment to State approving agency funds should not be construed as a violation of the contracting procedures followed for FY 1987.

The funds budgeted for State approving agencies in FY 1988 are sufficient to maintain the quality of veterans' education and training programs. Although a slight increase in veteran enrollments is expected, a corresponding increase in State approving agency workload is not. The slight increase is attributable to trainees pursuing programs under Chapters 30 and 106. In all likelihood the trainees will enroll in colleges and universities which are already approved for veterans' training and in which veterans and eligible persons are currently enrolled. The continuing decline in job training establishments and vocational and technical schools will more than offset any increase in workload at the colleges and universities.

We recognize and appreciate the difficult challenges facing both State and Federal governments. We hope to meet these challenges with the cooperation and assistance of State officials. It is essential that we work together to control spending and ultimately reduce the deficit.

We appreciate your concern and will do everything possible to maintain adequate payments to State approving agencies in the coming years.

Sincerely,

THOMAS K. TURNAGE
Administrator

HONORABLE WAYNE DOWDY

QUESTION 4: Your budget calls for a reduction of 16 FTEE in Vocational Rehabilitation and Counseling (VR&C). I am concerned about this proposed reduction.

QUESTION 4A: Two years ago we passed a program on a pilot basis for counseling of younger pensioners and unemployability compensation recipients. How well are you doing on these programs with your current personnel level?

RESPONSE 4A: Pension Recipients: The number of veterans evaluated has now increased due to the installation of a computer program which automatically identifies eligible veterans. At the inception of the program this identification process was done on a manual basis and many veterans were missed. During the first year of the program the VA did approximately 600 evaluations. As a result of the resolution of the technical and administrative problems described above this has increased to 1000 evaluations for the first six months of the second year of the program. On the basis of the number being provided evaluations during the first six months of this program year, we project that over 2000 veterans will be provided evaluations this year. That is close to the 2500 maximum evaluations which may be provided during any one year of the program. Currently, more VA pension recipients have been identified than can be scheduled for evaluation, primarily because of scheduling backlogs.

Individual Unemployability Compensation: During the first year and a quarter of the IU (individual unemployability) program we evaluated 460 veterans who had been awarded IU prior to February 1, 1985, and 44 veterans who had been awarded IU on or after February 1, 1985. We project that approximately 100 veterans with IU ratings will be provided evaluations during the second year of the program. We have not experienced administrative problems with the IU program due to the small number of cases requiring evaluation.

QUESTION 4B: How can you give these veterans the attention we intended for them to have with even fewer counseling personnel?

RESPONSE 4B: Although we will have fewer personnel to provide counseling services, we will make every effort to minimize any reduction in quality and timeliness. The impact on workload, backlogs, and quality of service delivery are of prime concern when the Department of Veterans Benefits must allocate staff reductions. We recently issued a circular which allows vocational rehabilitation field staff to contract for certain extended evaluation and employment services. We think that this will help the workload. We will continue to explore ways of streamlining work processes through automation and paperwork reduction.

QUESTION 4C: My understanding is that the Vocational Rehabilitation Specialist (VRS) workload has gone from 142 per VRS in FY 1977 to 177 per VRS in FY 1986. Reasonable quality services can be provided at a caseload level of about 120. Additionally, it can take as long as six months for a veteran to get an initial appointment to discuss his vocational rehabilitation plan. How can you recommend a reduction in FTEE with this caseload and backlog.

RESPONSE 4C: Refer to Response 4B.

HONORABLE WAYNE DOWDY

QUESTION 5: In your testimony before the Committee on February 3, 1987, you indicate support for legislation to make the new GI Bill a permanent program. I am delighted to see this and, in fact, am one of over 170 cosponsors of legislation to accomplish this. Unfortunately, you also include a recommendation to transfer budgeting for this program to the Department of Defense, characterizing the New GI Bill as a recruitment program for the Department of Defense.

QUESTION 5A: Would you agree that historically GI Bills have been first and foremost readjustment programs funded by the Veterans Administration?

RESPONSE 5A: We would agree that the Serviceman's Readjustment Act of 1944 (Public Law 78-346), the Veterans' Readjustment Assistance Act of 1952 (Public Law 82-550) and the Veterans' Educational Assistance Act (Public Law 89-358) have been primarily readjustment programs funded by the Veterans Administration. However, the purpose of the Post-Vietnam Era Veterans' Educational Assistance Act (Public Law 94-502) which is the first education benefits program for our peacetime, all-volunteer armed services, is to provide educational assistance to members of the Armed Forces, to assist those members in obtaining an education, and to promote and assist the all-volunteer military program.

QUESTION 5B: Would you agree that the first purpose listed for the New GI Bill in title 38, USC, is "to provide a new educational assistance program to assist in the readjustment of members of the Armed Forces to civilian life after their separation from military service..."?

RESPONSE 5B: Although readjustment is among the stated purposes of the New GI Bill, the VA traditionally has funded education programs aimed at providing readjustment benefits to conscripted war-time veterans. The New GI Bill's basic benefits, as well as the kickers, are used by DoD as a recruitment tool. Recruitment tools, including the previous peace-time education benefits program, traditionally have been funded by DoD.

QUESTION 5C: In view of this, I am certain that you will understand and personally agree with our view that the VA should continue to fund the basic benefit, which is the readjustment portion of the New GI Bill. I am aware that the VA appealed the OMB decision to transfer this funding and I appreciate that very appropriate support. Do you have any additional comments on this matter?

RESPONSE 5C: We do not have anything more to add.

HONORABLE WAYNE DOWDY

QUESTION 6: The Administration's budget request again contains no recommendation to extend the Veterans' Job Training Act (VJTA), citing improvements in both the economy and unemployment rates for Vietnam era and Korean Conflict veterans.

More than 50,000 long-term unemployed veterans have been put back to work under VJTA. A Congressionally-mandated study and evaluation of this program concluded that VJTA has had a significant positive effect on the employment rates and earning levels of participating veterans. Given the success of this program, wouldn't it be appropriate for the VA to advocate full and extended support for VJTA?

RESPONSE 6: Given the decrease in veterans' unemployment which has resulted since the inception of the Veterans' Job Training Act, we do not believe it is appropriate to request additional resources for the program. The employment situation for veterans has steadily improved, as is evident from the following information.

At the time this program was initiated in January 1983, the unemployment rate for Vietnam era veterans was 11.4 percent.

In February 1986, the unemployment rate was 6.6 percent.

In September 1986, the unemployment rate for Vietnam era veterans was 4.5 percent while the rate for the total civilian population was 6.8 percent.

In addition, legislation (S.539 and H.1155) to modify the Job Training Partnership Act to establish a workers adjustment assistance program has recently been introduced. If this legislation is enacted, approximately $900 million will be allocated for assistance to displaced workers. Since previous studies have shown that 25% of displaced workers are veterans, we expect that a proportionate amount of the total appropriation will be specifically earmarked for veterans. The VA will work closely with the Department of Labor in this endeavor.

Hon. Timothy Penny to VA

CONGRESSMAN TIMOTHY PENNY

Question 1: DULUTH OUTPATIENT CLINIC: As I and my Minnesota colleagues have expressed by letter to General Turnage, we are very interested in the development of the Duluth Outpatient Clinic and are concerned over the siting of that facility. We would appreciate an update on the progress of this project and the proposed planning and activation timelines. I would also appreciate an explanation as to why the VA seems to be moving away from long-established practice of locating facilities near the demographic center of the service areas. Locating the outpatient clinic in Superior, Wisconsin, which is less than one-third the size of Duluth and has fewer of the necessary support services, (as was explained in our delegation letter) does not seem to be consistent with former siting practices and not in the best interest of area veterans.

Answer: The acquisition of VA outpatient clinic space is proceeding on schedule. A team composed of VA Central Office and Minneapolis VA Medical Center personnel will conduct a market survey of proposed sites on March 3-6, 1987 in Duluth and Superior. All sites will be evaluated by the team. Those sites meeting VA criteria will be approved, and the person representing the site will receive a Solicitation for Offers in April or May, 1987. The projected lease award date for this 21,785 to 23,000 net square foot clinic is November 1987. The projected activation date is January 1989.

The Department of Medicine and Surgery considers the Duluth/Superior metropolitan area to be the population center of the demographic area which forms the veterans service catchment area developed for the VA outpatient clinic. Any site selected by the VA, whether located in Duluth or Superior, will meet accessibility requirements of DM&S.

HONORABLE TIMOTHY PENNY

QUESTION 2: ST. PAUL INSURANCE CENTER: The VA budget proposal again includes consolidation of the St. Paul and Philadelphia Insurance Centers. Early results of the GAO survey of this move, based on the original VA study, indicated that the consolidation seemed to be driven more by administrative desire for consolidation rather than actual budgetary savings. To date, the GAO has not completed its findings but will be proceeding with new data provided by the VA. What is this new data and how does it support the need for consolidation? What are the timelines for any consolidation and what activity is currently taking place in St. Paul and Philadelphia? Are you going ahead under the assumption that GAO will support the move?

RESPONSE 2: The Insurance consolidation was originally scheduled to commence in October 1986, but was postponed until FY 1988, due to Congressional action. Because of the delay, the Office of Management and Budget requested that the VA recompute the costs/savings associated with the consolidation using current data. The recomputed benefit-to-cost ratio has improved from the original study; the recomputed figures show that, once the one-time costs have been offset, annual savings in excess of $1.6 million will be achieved. Assuming that the consolidation is initiated in October 1987, as planned, the VA will begin to realize net savings in March 1989.

The consolidation is expected to be phased in over an eighteen month period. The planning schedule has remained essentially intact with the dates slipping one year due to the Congressionally-imposed delay. No action has been taken to date, or will be taken prior to October 1, 1987, at either site to effect the consolidation.

Although a final report has yet to be issued by the GAO on this subject, two previous studies conducted by the GAO (in 1962 and 1969) have recommended the consolidation of the Insurance activity. We do not expect their current findings to dispute the results of their prior studies in this area. Since their results are expected shortly, and since our own recomputation of the savings continues to support the cost-effectiveness of this initiative, we have included the consolidation in the FY 1988 budget.

QUESTION 3: BUILDING 43: I have made clear my interest in the VA planning process. In that regard, I was advised by letter from Col. DeWire that VA plans for utilization of Building 43 would be made known to me by November 30, 1986. I have not yet received those plans even though the activation of the new Minneapolis VAMC is scheduled for late summer of this year. Will you please supply me with this plan?

RESPONSE 3: The report on ways to utilize Building Number 43, VA Medical Center, Minneapolis, Minnesota, is in the final stages of concurrence before presentation to the Administrator. The compilation of the report and the review process has taken longer than originally anticipated because of the need to fully assess the options available and gather the necessary data to draw sound, managerial conclusions involving each option explored.

At the earliest possible date, the Report will be released to the House and Senate Veterans' Affairs Committees.

Hon. Marcy Kaptur to VA

HONORABLE MARCY KAPTUR

QUESTION 1: From the submissions we have seen, you anticipate a heavier workload in loan processing. Additionally, your workload reports indicate that loan servicing in many stations is considerably backlogged. How do you expect to cope with this increased workload with only 12 additional people?

RESPONSE 1: The Department has taken a number of steps to process the heavy volume of appraisal and loan origination workloads during the past year.

- Lenders have been strongly encouraged to process their loan applications on the automatic basis. Currently 79 percent of GI loans are processed in this manner compared with 53 percent a year ago.
- Field stations have been using contract personnel for reviews of appraisals and loan submissions which has greatly assisted many offices in reducing backlogs and improving timeliness.
- In April 1986 GNMA (Government National Mortgage Association), no longer required VA's CRV (Certificate of Reasonable Value) on GI interest rate reduction refinancing loans. Therefore, lenders processing loan applications for veterans refinancing their loans did not have to request new appraisals from VA. This resulted in a significant reduction in appraisal workload.
- The Department continues to make progress in improving the Loan Guaranty systems as part of the modernization effort. We continue to work towards more on-line capability and we have initiated a major effort to automate the origination process.

Continued emphasis on automatic loan processing, judicious use of contract funds, and modernization, coupled with an increase in employment, will enable us to provide an acceptable level of service with the employment requested.

Question 2. In legislating the grant-in-aid program for states to establish veterans' state cemeteries, it was contemplated that the states would be sharing some of the Federal Government's burden in meeting the burial needs of veterans. Wouldn't we be breaking faith with the states which have assumed their share of the veterans' burial needs if we terminate the plot allowance as you recommend?

Response 2. The Federal Assistance program to aid States in the establishment, expansion or improvement of cemeteries for veterans was enacted to help States provide an alternative burial option for veterans who reside in areas not currently served by a national cemetery. The grants, as authorized by law, provide for up to fifty percent of the costs associated with the acquisition of land and the cost of construction to convert that land into a cemetery.

In encouraging States to establish cemeteries for veterans they are advised that the Administrator of Veterans Affairs is authorized to pay an allowance of $150 (plot or interment allowance) to the State for expenses incurred in the burial of eligible veterans in cemeteries owned and operated by such State. These allowances are paid to the states as a reimbursement, with the states assuming responsibility for disbursement. The two programs - State Cemetery Grants Program and plot allowance - are two separate and distinct programs. Although they may enhance one another, they are intended to operate as independent programs. It is not known at this time what impact, if any, the elimination of the plot allowance will have on states contemplating the establishment of veterans' cemeteries.

HONORABLE MARCY KAPTUR

QUESTION 3: You propose legislation to change the VA Administrator's authority to set interest rates. Since FHA has had a floating interest rate over the last several years, would you please advise us what percentage of FHA loans were issued at a rate lower than the VA's or at a higher interest rate last year?

RESPONSE 3: The VA was recently provided Calendar Year 1986 data from FHA. Since this data is specified in interest rate ranges, we are unable to provide the percentage of FHA loans issued at a rate higher than the VA's. During that period, approximately 9.3 percent of FHA loans were below the VA rate; 90.7 percent were insured at or above the VA rate.

QUESTION 4: Participation certificates were issued several years ago. The budget document indicates that you now need approximately $143 million for redemption purposes. Will you please explain how this came about?

RESPONSE 4: The Participation Sales Act of 1966 (PL 89-429) authorized the Federal National Mortgage Association (FNMA) (later known as Government National Mortgage Association (GNMA)) to act as trustee and pool loans from 6 agencies and sell participation certificates. Principal and interest collections received by LGRF were transferred to GNMA for payment to the participation certificate holders. Funds not used to pay interest to the certificate holder or retire certificates were invested by GNMA and credited to the Fund. The Fund in turn recorded these accrued investment earnings as budgetary resources in the form of accounts receivables, which are used in the calculation of unobligated balances. Obligations for program expenses were partially funded from these unobligated balances.

When GNMA finally does transfer all funds being accrued and which we have been recording as a budgetary resource, the cash will be used to offset the accounts receivables VA has recorded over the years. At that time, loans currently pledged to the trust will be released and available for sale, in early FY 1989. To make up for the loss of these budgetary resources, an appropriation is needed to re-establish a level of unobligated balances that allows the Fund sufficient flexibility for its program operations.

QUESTION 5: Previous budgets have proposed increased origination fees. These proposals have been consistently rejected by the Congress. P.L. 99-576 specifically expressed the sense of the Congress that it not exceed 1%. Why then is this proposal to increase the origination fee to 2.5% in the budget? Doesn't this constitute phony revenues?

RESPONSE 5: No, this does not constitute "phony" revenues. The increase in the funding fee is necessary to offset losses sustained by the Government due to the foreclosure of guaranteed loans. Since FY 1978, almost $2 billion in appropriations and transfers from other accounts have been necessary to support the Loan Guaranty Revolving Fund. The additional revenue from the increased fee will make the revolving fund self-sustaining without placing an undue hardship on veteran beneficiaries. If the fee were financed (as most are), the average veteran's monthly mortgage payment would be increased by only $9. If the fee is not increased, Congress will have to appropriate $389.8 million in 1988 to support the fund.

HONORABLE MARCY KAPTUR

QUESTION 6: Two years ago, you proposed an origination fee of 5%. Last year, you wanted it to increase to 3.8% over a four-year period. Now you are requesting 2.5%. How are you determining these percentages?

RESPONSE 6: Long range projections of obligations and receipts to the Loan Guaranty Revolving Fund indicate that the fund will continue to experience substantial deficits each fiscal year under existing legislation. In order to balance the fund over the long term, additional revenue will be necessary. Our projections show that if the funding fee is increased to 2.5 percent by June 1, 1987, the fund will be self-sustaining.

QUESTION 7: What impact will an increased origination fee have on a veteran's ability to acquire a home?

RESPONSE 7: The increase in the funding fee from 1 to 2.5 percent will have a very minimal impact on the ability of veterans to acquire a home. Almost all veteran purchasers elect to finance the funding fee over the life of the loan. At the current maximum home loan interest rate of 8 1/2 percent on an average home loan of $75,000 the veteran's monthly payment would increase by less than $9, ($576.75 increased by $8.65 to $585.40). Even at higher loan amounts and interest rates the monthly payment differential would be minimal.

Question 8. The position of Chief Memorial Affairs Director has been vacant for over a year now. When do you plan to fill it?

Response 8. We anticipate within the next 90 days the position of Chief Memorial Affairs Director will be filled.

Question 9. The Department of Memorial Affairs budget shows a reduction of 32 positions for contracting and productivity improvements. Will these reductions adversely affect service to veterans and what specific cemeteries do you plan to specifically contract out?

Response 9. It is not anticipated that this reduction will have a significant impact on the quality of service provided to our nation's veterans. The reduction of 32 positions was partially offset by increases provided for workload growth and the opening of the Florida National Cemetery.

The DMA has for many years contracted operations at small, inactive cemeteries under authority established in Section 1004, Title 38, United States Code. At the present time 25 national cemeteries operate under this type of service contract. These are inactive cemeteries which perform very few interments each year, or in some cases none at all. Supervision at contracted cemeteries is provided either by a VA employee assigned full-time to the facility, or by VA personnel from another national cemetery in the vicinity. Our experience with contract maintenance in these types of situations has generally been positive. The Department plans to continue this policy and is currently considering St. Augustine, Florida; Wilmington, North Carolina; and Annapolis, Maryland for contracting out in FY 1988, for a total expected savings of approximately 6 positions. The balance of the savings to be realized in employment will be accomplished through productivity improvements.

HON. GERALD B.H. SOLOMON TO VA

Congressman Gerald Solomon

Question 1. I assume the VA is moving ahead with plans for testing for illegal drug use. What is your timetable and the costs of such a program?

Response 1. We are aiming to begin the testing program for executives and managers in April. We plan to begin the testing for others as soon as possible thereafter. The testing will be done on a phased-in sampling basis. We will develop cost estimates as soon as we have determined the implications for VA laboratories of the recently issued technical guidelines by the Department Health and Human Services.

Question 1A. Will the unions get an opportunity to review the procedure and process before it is implemented?

Response 1A. Yes, we will provide the unions the opportunity to review our policies and procedures before we begin testing of employees included in union bargaining units.

Question 1B. How can the VA proceed with the planning for this testing in light of the recent court decisions invalidating the Customs Service plan?

Response 1B. We have been advised by the Justice Department that it believes that the Order by which the Customs Service's drug testing plan was enjoined ("the Von Raab Order") "was wrongly decided and constitutes an extreme and largely unprecedented holding on the merits;" that an appeal of the Von Raab Order would be pursued vigorously; that the terms of the injunction apply only to the Customs Service, and only to that agency's drug testing program, which was put into effect prior to, and independent of, the Executive Order which the VA is now proceeding to implement; and that, accordingly, the VA is not legally barred from planning for the implementation of Executive Order 12564.

Question 1C. Will this Committee get an opportunity to review the procedure and process before it is implemented?

Response 1C. We will be happy to provide the Committee copies of our policy issuances after they have been prepared.

HONORABLE GERALD SOLOMON

QUESTION 2: The budget proposal would eliminate some 75 Veterans Benefits Counselors. My question is do you have enough people to do your outreach activities such as your telephone hotlines, benefit counseling, and aid to the homeless veterans?

RESPONSE 2: The FTEE level requested in the FY 1988 budget will be adequate to provide continued good service to our veteran population. In FY 1986, Veterans Assistance programs experienced a 5 percent increase in productivity over the base year 1985. Similar increases in productivity are anticipated in FY 1987 and 1988. All Veterans Services activities met or exceeded the quality and timeliness standards in the manual with the exception of telephone services. However, the recent consolidation of Veterans Services Division work elements at many of our regional offices will provide more staff resources for our our telephone service program, which should result in some reduction in the abandoned-call rate in 1987 and 1988. Service to veterans will also be enhanced by the use of new call handling equipment at a number of field stations. Finally, our Veterans Assistance Service is also researching the use of telephone audio information systems to provide general benefits information to the public. All of these changes should permit us to provide quality service to veterans and their dependents in a timely manner despite the projected declines in staffing. This includes outreach and information and referral service to homeless veterans as well as to other target populations.

QUESTION 3: Does consolidation of the St. Paul and Philadelphia insurance operations take into account moving costs, termination pay, and taxation losses?

RESPONSE 3: The Veterans Administration (VA) Fiscal Year 1988 Budget includes $1.177 million in FY 1988 General Operating Expenses to accomplish the Insurance consolidation. An additional $0.293 million will be needed in FY 1989 to complete the consolidation. These one-time costs include the estimated personnel relocation/separation costs, the cost of training new employees, the cost of shipping equipment and files from St. Paul to Philadelphia, and the costs associated with notifying insureds of the change of address. No adjustments have been made to reflect changes in tax revenues.

In addition to these costs, an anticipated $53,000 will be required to install the Insurance Terminal System (ITS) in Philadelphia and remove ITS cabling from St. Paul. These additional monies will be provided from the VA's Minor Construction Fund. The following Table illustrates the specific cost components.

TABLE 1: CONSOLIDATION ONE-TIME COST COMPONENTS

Description	FY 1988	FY 1989	TOTAL
Early Retirement (Lump Sum)	$57,330	$37,485	$94,815
Termination of Employment:			
Severance Pay	142,103	33,436	175,539
Lump Sum Annual Leave	37,485	8,820	46,305
Unemployment Compensation	85,527	20,124	105,651
Cost of Processing Out	17,499	7,368	24,867
New Hires	3,264	672	3,936
Training*	192,769	49,313	242,082
Household Moves	350,000	75,000	425,000
Movement of Equipment/Files	0	61,830	61,830
Notification of Insureds	289,636	0	289,636
Minor Construction (Non-GOE)	46,100	6,600	52,700
TOTALS	$1,221,713	$ 300,648	$1,522,361

* Salaries for new trainees are reflected in recurring Personnel Costs (higher staffing levels in FY 1988 and 1989, during the consolidation).

HONORABLE GERALD SOLOMON

QUESTION 4: Last year it was indicated that a comparatively large number of veterans who were disabled in the 10% and 20% categories were receiving vocational rehabilitation. Are you monitoring this program closely to assure that only those truly in need of rehabilitation are granted this benefit?

RESPONSE 4: Two points are at issue in this question. First, when using comparative statistics, it should be noted that a relatively large potential population of disabled veterans exist in those rated 10 and 20%; since these categories comprise over 55% of veterans receiving service-connected compensation. But while over one-half of veterans receiving compensation are so rated, we find that only 45% of the total applications for vocational rehabilitation services come from these veterans. The second important point is that the degree of service-connected disability assigned by the Rating Board through its schedular process does not assess the current functional employment impairment of the veteran. The need for vocational rehabilitation is determined by a counseling psychologist who makes this type of assessment and determines that the service-connected disability(s) materially contributes to the veteran's employment handicap. Eligibility determinations are monitored both by field stations and Central Office staff through the statistical quality control and systematic analyses of operations processes. Although we have found no significant deviation from program guidelines, we currently are undertaking a benefit/cost study in which we are examining the program by levels and types of disability.

QUESTION 5: The budget contains major construction funding for colocating the Wichita Regional Office. Why only for one regional office? Is this the rate to be proposed in the future budgets?

RESPONSE 5: The Agency has a committment to pursuing colocation, where colocation is in the clear interests of both the VA and the government. During the preparation for the 1988 budget request, the Wichita colocation project proved to be the only cost-effective project under review at that time. Our analysis has included cost benefit studies, an assessment of the current status of non-VA government owned or leased facilities, and the potential service delivery benefits. A review of several additional sites for possible colocation has begun. In the future, colocation projects will be proposed when they are proven to be cost-effective and within available budget constraints.

QUESTION 6: Some time ago when it was proposed to eliminate the burial plot allowance, the administration told us that corollary information resulting from the grant of the plot allowance was extremely helpful to the government. What caused a change in your position with respect to this benefit?

RESPONSE 6: The primary reason the plot allowance eligibility was not changed in 1981 along with the basic burial allowance was that a vehicle was needed to receive death certificates for research purposes. Since 1981, we have not been receiving the same percentage of death certificates as we were before the burial allowance criteria was changed. In addition, the death certificates are state issued and can be obtained from state records which now would be more complete than VA records.

In this era of fiscal restraint we would be able to save $31 million without causing much, if any, hardship on VA beneficiaries and without significant effect on receipt of death certificates.

Congressman Solomon

Question 7. What is the personnel impact in the Veterans Administration with respect to absorbing pay increases and with respect to absorbing the costs of the new retirement system?

Response 7. In the General Operating Expenses (GOE) account a supplemental appropriation request is pending before Congress for the total cost of the new retirement system. However, there was full absorption in this account for pay increases. Central Office Staff offices were able to accommodate the pay raise within their operating budgets primarily because FTE remained under plan through the first quarter thus making personnel dollars available for this purpose. FTE was lower than planned since budget constraints and hiring freezes during FY 1986 lowered FTE going into 1987; funding uncertainty because of beginning year continuing resolutions did not allow the rapid recovery planned. The Department of Veterans Benefits reduced FTE by 36 to absorb the cost of the pay raise and to better manage resources to meet future FTE requirements.

Question: 8. Does the 1988 budget provide for all previously planned facility activations?

Answer: The 1988 budget does provide for all previously planned facility activations. Resources for all 1987 annualizations and 1987 estimated project slippages are included in the 1988 budget request.

Question: 9. Of the total research budget, how much is allocated to prosthetics?

Answer: The President's budget for Research and Development in FY 1988 is $198,766,000 and for Rehabilitation Research and Development (RR&D) the request is for $8,584,000. Rehabilitation R&D estimates that $5.4 million will be obligated to support 58 projects in the area of prosthetics/amputation research.

Question: 10. The administration proposes the elimination of Category "C" patients. It does this by a proposed rescission of $75 million in FY'87 and by total elimination in FY'88. This category of veterans was deliberately established by the Congress just last year. What is the justification for the Administration's proposal?

Answer: Nonservice-connected veterans determined to be in eligibility Category "C" have no service-connected disabilities and have higher incomes (greater than $20,260 for a single veteran, $25,236 for a veteran with one dependent) and therefore significant monetary resources to purchase necessary medical care. This administration believes that as a rule when veterans' illnesses are completely unrelated to their military service and they are financially able to provide for their own health care, they should do so. However, in locations where resources and space remain available, the VA will continue to furnish care to nonservice disabled veterans with incomes above these levels. This practice will allow the VA to concentrate its efforts on service-disabled veterans and those least able to finance the cost of their own health care. It carries out the provisions of the Veterans Health Care Amendments of 1986, which established the current set of eligibility criteria for veterans' health care.

Congressman Solomon

Question: 11. Have there been any instructions to the field stations with respect to reduced employment based on the 1988 budget submission?

Answer: There have been no instructions to the field that they should reduce employment now based on the FY 1988 budget submission.

Question: 12. A 1% increase in productivity in the Department of Medicine and Surgery translates to a decrease of employees. How do you define productivity in this context?

Answer: The basis for a productivity increase is that currently planned Medical Care workloads, and the quality of care, can be maintained with less employment. The important output measures in Medical Care are patient workloads; specifically, VA hospital patients treated and outpatient staff visits. In 1986, the combined actual employment in the hospital and outpatient activities decreased .8%. However, actual workloads increased 1.7% for patients treated and 3.8% for outpatient.

Because actual employment change is dependent upon the net of many factors (to include facility activations, productivity resource reductions, etc.), it is important to look at the differences in the rate of changes between employment and workload. The bottom line for 1986 is that workload increased while employment did not; which indicates that the VA Medical Centers, continue to show productivity improvements even exceeding budgeted productivity related resource reductions.

During the first quarter of FY 1987, VA health care facilities processed 685,512 applicants. Of this total, only 353 veterans, or one-twentieth of one percent, had to be referred to the community because the treatment modality was not available in the VA.

QUESTION 13: What is the trend with respect to the number of veterans receiving compensation? In this connection, in one of your statements you indicate that the average degree of disability is going down. To what do you attribute this?

RESPONSE 13: The trend with respect to the number of veterans receiving compensation is downward. As the veteran population declines and the number of active duty personnel is maintained at a peacetime level, the pool of candidates for compensation is also reduced. We would expect the decline in compensation recipients to moderate as the career military personnel who entered active duty during the Vietnam Era are approaching retirement eligibility. The increases in military retirement payments may have had an impact on the number of persons claiming VA compensation despite the tax advantage of the VA payments.

Between September 1981 and September 1985, the average combined disability evaluation declined from 30.8 percent to 30.5 percent. While this might have a budgetary impact considering the millions of veterans involved, the decline may not be statistically significant to the individual veteran. We would attribute what change there is to a declining wartime veteran population amongst whom we would expect more severe injury, and to the possible stablization of those injuries incurred by Vietnam Era veterans. We would also expect advancements in medical treatment to have had some part in the lessening of the severities of disabilities DVB evaluates.

CONGRESSMAN GERALD SOLOMON

QUESTION 14: There is a reduction of almost 300 employees in the Department of Veterans' Benefits in this proposed budget. How many of these individuals are involved with the processing of claims? Are you currently meeting your own standards in such processing and will you provide detailed information to the Committee in this regard?

RESPONSE 14: Included in the 296 FTEE reduction in 1988 are modernization savings of 117 and Insurance savings totalling 13. The balance of 166 FTEE is associated with the workload reductions and productivity increases in processing of claims. The Department is currently meeting most of its own standards in such processing. Based on past trends, it is expected that there will be some productivity increase in 1988. We do not anticipate that there will be any specified declines in timeliness and quality of service from the current year level. The FTEE level requested in the 1988 budget will provide continued good service to our veteran population.

Question 15. Does the reduction in general operating expenses involve any Central Office personnel?

Response 15. Yes, approximately 13 FTE in the Department of Veterans Benefits.

Question 16. To what extent has this budget shifted toward the goal of distributing the nursing home care, provided mix on a national basis to 30 percent VA owned, 40 percent community nursing home care and 30 percent state nursing home care?

What effect does this shift have on construction projects for nursing home care units?

Answer: The proposed FY 88 budget represents the second year of a shift towards the 30-40-30 stated goal. All three programs have shifted a few percentage points with the most significant being in the State Nursing Home program which will move from 26% in FY 1986 to 28% in FY 1988. Planned conversion of 1086 hospital beds to nursing home care beds have been identified but the largest number will be not be converted until after FY 1988. 282 beds are planned for conversion in 1988.

Approximately 1000 new nursing home beds will be activated after 1988 as a result of projects under construction.

Congressman Gerald Solomon

Question 17: Does the VA anticipate increased success in liquidating overpayments and other debts owed it?

Response 17: Over the course of the last year, the VA has incorporated four major debt collection tools in our collection process. The first of these is the referral of delinquent debts to credit reporting agencies for the purpose of affecting a debtor's credit rating. The second is the use of private collection agencies. The VA referred debts valued at $425 million to collection agencies during calendar year 1986. The third is the IRS income tax refund offset program. During fiscal year 1986, the VA referred 32,000 debts valued at $31 million to IRS. Collections totaled over $8 million. In fiscal year 1987, we referred 297,000 debts valued at $390 million. We anticipate over $50 million in collections. The fourth collection tool is the Federal Salary offset program which was installed in January 1987. Efforts are underway to perform computer matches with all Federal agencies to identify individuals indebted to the VA. They will be notified and given an opportunity to establish a repayment plan. If they refuse, action will be taken to offset their salary to recoup the debt. As a result of these initiatives and the current efforts underway to incorporate the telephone in our collection procedure, we anticipate considerable success in the area of debt collection.

Question: 18. You request that Congress approve the elimination of Category "C" patients. Yet, you leave open the possibility that some such patients would be treated at stations which have excess funds. How would you administer this program? Is it not true that elimination of Category "C" patients would also jeopardize Category A and B patients?

Answer: Health care facilities with sufficient resources to treat Category "C" veterans would determine locally if they could provide the medical care necessary for the Category C nonservice-connected veteran. Elimination of Category C veterans would not jeopardize Category A veterans and Category B since these veterans by law have a high priority for medical care.

Question 19. If a station had excess funds over and above its needs for category A and B patients, would not the Department of Medicine and Surgery withdraw those funds and allocate them to an underfunded station?

Answer 19. The first priority is to take care of category A and B veterans. If a station were underfunded for these categories some funding redistributions would have to be made, however, this would not occur if stations were properly funded for category A and B.

The Department of Medicine and Surgery would then not withdraw funds and allocate them to another station. The stated policy is that medical facilities will continue to provide treatment to veterans to the degree they have capacity to do so. These funds are not considered excess to their needs.

HONORABLE GERALD SOLOMON

QUESTION 20: The GI Loan Guaranty Program has operated since 1944 with an interest rate established by law. It has been a highly successful program. What is the justification for recommending that interest rates now be negotiated between the home buyer and the lender?

RESPONSE 20: When the cost of money is not adequately reflected by the VA rate, lenders charge points to make up the difference in their yield. One point equals one percent of the loan amount. The points are payable in cash at closing. Since, by law, veterans may not in most instances pay the points, the seller normally pays them. Because of this, sellers often refuse to sell with VA financing or increase the selling price of the home to reflect the anticipated points. In neither instance is the veteran benefited.

Under the proposal, the veteran buyer, the seller, and the lender can negotiate on whether the rate, and thus the monthly payment, will be lowered in exchange for a certain number of points, and, if it is, who will pay some or all of such points. Thus, the transaction can be tailored to fit the needs and circumstances of the parties involved.

This change would be consistent with the Administration's goal of reducing Federal regulation and permitting market forces to operate.

QUESTION 21: If the Administration's proposal to increase the origination fee on GI loans were to be adopted, how many veterans might be forced out of the market?

RESPONSE 21: The VA's FY 1988 budget submission includes a 5 percent decrease in loan volume in connection with the higher fee. However, this does not mean 5 percent of the potential veteran buyers would be prevented from obtaining GI loans. We estimate that most of the fall off would come from higher income veterans who have alternative mortgage financing opportunities available to them. A very high percentage of veterans add the funding fee to the loan amount. At the current maximum home loan interest rate of 8 1/2 percent on an average home loan of $75,000, the veteran's monthly payment would increase by less than $9, ($576.75 increased by $8.65 to $585.40). Because monthly payments increase by such small amounts relative to the total monthly payments, it is difficult to see how the increased fee would deny many veterans an opportunity to use their home loan entitlement.

QUESTION 22: It has been indicated that the sale of your portfolio "without recourse" would be of great assistance to you. The Committee has received information that sales without recourse would cause the Veterans Administration to lose about 30% of income that would otherwise be received. How do you equate these two matters?

RESPONSE 22: The FY 1988 budget submission contains a proposal to sell $900 million of VA's loan portfolio ($300 million each fiscal year 1988-1990). The receipts from these loan sales are projected to be $210 million each fiscal year. The financing needs of the program are such that $630 million in cash over the next three years would significantly bolster the Revolving Fund. In contrast, the cash flow from these poor quality loans is uncertain and could vary considerably in the future because nearly 2/3 of the loans slated for sale are in a state of chronic delinquency.

CONGRESSMAN SOLOMON

Question: 23.A. Please give us the number of the pending applications for State homes that are currently under consideration by Central Office.

23.B. Please also predict the amount of activity in this program over the next few years.

Answer: As of December 31, 1986, the VA had on hand 64 eligible preapplications pending approval totaling $175.9 million (see attached list). In Fiscal Year 1986, the VA received 7 preapplications compared to 18 preapplications in Fiscal Year 1985 and 19 preapplications in Fiscal Year 1984. One preapplication has been received so far in Fiscal Year 1987 but we expect to receive preapplications from Virginia and Kentucky and additional preapplications for Tennessee, Florida, and other States that do not currently have a State home. We also expect continuing activity in States with existing homes which need remodeling to meet current standards and which wish to expand their State home facilities as veterans become older and the need for nursing home care becomes greater.

Eligible Preapplications and Applications for
Grants for Construction of State Extended Care Failities
(Pending approval - dollars in thousands)
12/31/86

Assurance of Adequate State Funds	FAI No.	State (locality)	Project	Estimated Grant Request
	24-003	MD (Charlotte Hall)	(3rd Phase - 126 Dom/NH Beds)	3,047
	24-004	MD (Charlotte Hall)	(4th Phase - 126 Dom/NH Beds)	5,298
Received	28-001	MS (Jackson)	New State Home - 150 Bed NH	4,388
Received	25-029	MA (Chelsea)	Elevators	78
Received	25-030	MA (Chelsea)	Renovations	80
	13-004	GA (Milledgeville)	150 Bed NH	4,550
Received	27-006	MN (Hastings)	Grant Increase	474
Received	17-010	IL (Quincy)	Life-Safety-Fire Alarm	144
Received	42-009	PA (Hollidaysburg)	Renovate Dietary Building	1,800
	06-013	CA (Yountville)	Rem. Sec. B to Dom Life Safety	2,180
	06-015	CA (Yountville	Rem. Sec. E Life Safety	1,991*
	06-016A	CA (Yountville)	Rem. Hospt. Support Svc. Phase I	455
	06-016B	CA (Yountville)	Rem. Hospt. Support Svc. Phase II	845
	06-017A	CA (Yountville)	Rem. Nursing Home 1-3 A	1,322
	06-017B	CA (Yountville)	Rem. Nursing Home 1-3 B	1,465
	06-018	CA (Yountville)	Rem. Dom. Sec. F - Handicapped	2,365*
	36-002	NY (Long Island)	New 350 Bed NH	16,510
	06-020	CA (Yountville)	Rem. Sec. H Dom-Fire & Safety	862*
	06-021	CA (Yountville)	Rem. Sec. J Dom-Fire & Safety	892*
	06-022	CA (Yountville)	Rem. Sec. K Dom-Fire & Safety	606*
	06-023	CA (Yountville)	Rem. Sec. L Dom-Fire & Safety	683*
	06-024	CA (Yountville)	Rem. NHC Wings 1-3C-D	3,120*
Received	05-002	AR (Little Rock)	Conversion 70 Dom Beds to NH	195
Received	42-008	PA (Hollidaysburg)	Renovation-Sommer-225 NH Beds	4,091
	44-003	RI (Bristol)	Domiciliary-Renovation	1,138
	12-001	FL (Lake City)	New State Home 150-Bed Dom	4,083
	29-004	MO (St. James)	Replace NHC Unit (+50 beds)	2,420
	16-002	ID (Boise)	Renovation Dom/NHC Beds	1,334
	39-009	OH (Sandusky)	Power Plant	1,409
	06-025	CA (Yountville)	Remodel NHC Wards 2-3 E	2,512*
	06-026	CA (Yountville)	Remodel Annex I NHC	2,891*
	06-027	CA (Yountville)	Remodel Annex II NHC	2,381*
	06-034	CA (Yountville)	Remodel Ground & 1st Fl. Hosp.	650
	06-028	CA (Yountville)	Remodel Dom Sec. G & LSC	2,600*
	06-031	CA (Yountville)	Renovate Kitchen & Dining Room	1,424*
	06-032	CA (Yountville)	Renovate Hospital Food Service	46*
	06-029	CA (Yountville)	Renovations-Storage Areas	195
	06-033	CA (Yountville)	Renovations-Sprinkler System	65*
	06-035	CA (Yountville)	Renovations-Admin. Building	325*
	39-003	OH (Sandusky)	New 300 Bed Dom Replacement	9,223
	39-010	OH (Sandusky)	New 300 Bed NHC/Dom	9,728*
	01-001	AL (Alexander City)	New 150 Bed NHC	4,615
Received	29-005	MO (Cape Girardeau)	New 150 Bed NHC	5,850

Assurance of Adequate State Funds	FAI No.	State (locality)	Project	Estimated Grant Request
	29-006	MO (NW)	New 150 Bed NHC	5,850
	42-010A	PA (Pennhurst)	Remodel for 75 Dom Beds	203
	42-010B	PA (Pennhurst)	Renovations for 75 Dom Beds	203
	42-010C	PA (Pennhurst)	Renovations for 180 NHC Beds	3,621
	42-011	PA (Pennhurst Phase II)	Construct 270 NHC Beds	7,670
Received	45-002	SC (Anderson)	New 220 Bed NHC	5,785
	55-011	WI (King)	Renovate NHC Unit	3,187
	16-003	ID (Eastern ID)	New 22 Dom/60 NHC	2,979
	19-026	IA (Clarinda)	Remodel for 68 NHC	2,118
	19-027	IA (Marshalltown)	Dietary Facility	1,841
	23-002	ME (Biddeford)	New 120 NHC	4,875
	26-004	MI (Macomb)	New 170 NHC/84 Dom	3,307
	40-012	OK (Clinton)	Dining/Kitchen Facility	1,034
	42-012	PA (Pennhurst)	Dietary Facility	2,373
	42-013	PA (Hollidaysburg)	Air Conditioning NHC/Dom	1,047
	25-031	MA (Holyoke)	Life Safety - Sprinkler	320
	29-007	MO (St. Louis)	New 150 Bed NHC	5,850
	47-001	TN (Pending)	New 150 Bed NHC	5,525
Received	17-011	IL (LaSalle)	New 120 Bed NHC	4,680
	08-008	CO (Walsenburg)	New 120 Bed NHC	2,925
	46-009	SD (Hot Springs)	Life Safety Renovations	192
				175,915

Hon. Paul E. Kanjorski to VA

CONGRESSMAN PAUL E. KANJORSKI

Question: 1. In your written testimony, you mention the fact that the veterans' population as a whole is getting older, and that an older veterans' population has different medical needs than a younger population. Nevertheless, the budget you have presented today fails to request funds for the construction of new nursing home care beds at VA hospitals. Instead, it relies upon converting existing beds to nursing home beds. Would you please comment on the advantages of converting existing beds to nursing home use over construction of new beds? Also, are there instances where converting beds is inappropriate?

Answer: Converting existing hospital beds to nursing home beds has the following advantages.

- the acquisition of nursing home beds would not be dependent upon or impact on the VA construction budget. (some conversion costs would be necessary)

- the time for acquiring nursing home beds would be reduced.

- since the beds are established, the activation cost, such as equipment and furnishing, may be reduced.

- existing resources would be available to provide nursing home care.

- excess medical center beds would be utilized.

The hospital beds can only be of use to the nursing home program if they exist where there is a projected demand for nursing home care.

- beds available for conversion may be in a space which does not meet criteria; for example, for wheelchair accessibility.

- beds may be located in space where patients will be continually exposed to nosocomial infections.

Question: 2. What do you recommend in cases where there is a growing need for nursing home beds, but the VA hospital cannot spare inpatient beds to convert for nursing home use?

Answer: In planning to meet the veteran demand for nursing home care, medical districts are to first consider the availability of community nursing home beds in which to place veterans on a contractual basis or placement of the veteran in a State Veterans Nursing Home. Only after these two modalities have been considered is expansion of the number of VA owned and operated nursing home beds to be planned. Even then, the medical district must first evaluate the possibility of redesignation of existing, available hospital beds. If there remains unmet veterans needs after the above alternatives have been exhausted, requests for funding of VA nursing home care unit construction projects can be submitted for possible budgetary consideration.

CONGRESSMAN PAUL E. KANJORSKI

Question: 3. The VA relies upon private nursing homes to care for veterans who cannot be immediately admitted to VA nursing home units. Do you consider the contracting-out of nursing home services to private nursing homes a realistic solution to the shortage of nursing home beds?

Answer: The VA, through the Community Nursing Home Program, contracts with over 3,600 private nursing homes nationwide. These nursing homes will treat over 40,000 veterans in 1988. The purpose of the program is to provide skilled and intermediate nursing home care to veterans in a facility close to their family and community. By law, most non-service disabled veterans are eligible for this program only following a hospitalization at a VA medical center. The placement period at VA expense allows time for the veteran to make the transition from the hospital to the community or allows the veteran and family to make plans for continued care, through private pay or medical assistance. Service-disabled veterans are not subject to these restrictions.

The Community Nursing Home Program is one component in the VA's plan for nursing home care. The other programs are the VA Nursing Home Program and the State Home Program. The VA plans to expand all three programs in the future to assist in meeting the nursing home care needs of veterans. The VA's goal is to serve 12-16 percent of all veterans in need of nursing home care on any given day. The VA plans to provide 30 percent of that care in VA-operated facilities; 40 percent of the care in Community Nursing Homes; and 30 percent of the care through the State Home Program. The Community Nursing Home Program has been and will remain a vital component of the VA's nursing home strategy.

Question: 4. The majority of veterans are only eligible for 6 months of VA-sponsored care at a private nursing home. The VA Nursing Home Unit in Wilkes-Barre has veterans who have been on the waiting list for two years or more. Would you like to comment on this situation?

Answer: By law, the VA can only pay for up to 6 months of care in a Community Nursing Home as a follow-up to a period of VA institutional care for non-service disabled veterans. In contrast, there are no statutory limitations on the length of stay in VA-operated nursing homes. Any veteran in need of nursing home care can apply for and be placed on the waiting list for VA Nursing Home Care. Placement priorities govern this process. These priorities provide that service-connected veterans will be admitted before nonservice-connected veterans. All veterans are informed of the priority system and the potential of a long waiting list when they apply for VA Nursing Home Care.

Question: 5. Are you aware that a $4.1 million, 60 Bed addition to the Nursing Home Care Unit at the Wilkes-Barre VA Hospital was authorized by this committee in Fiscal Year 1986 and 1987?

Answer: Based on the authorization as well as the directive contained in Congressional Conference Report 99-363, the project was included in the FY 1986 working drawing design fund request. Preliminary design of the project was completed in October 1986.

CONGRESSMAN KANJORSKI

Question: 6. Are you also aware that funds were appropriated by the Congress for the design of this project in FY 1987? And are you aware that your budget does not recommend the funds necessary to begin construction of this facility in Fiscal Year 1988, as has clearly been the intent of the Congress?

Answer: The preliminary design for the Wilkes Barre nursing home was completed in October 1986. The project has been included on the VA's FY 1986 working drawing design fund list, but working drawings have not yet begun. The conference report which established the design fund directed that the design fund should only be used for those projects for which construction funds will be requested in the following year. Due to systemwide priorities, the Wilkes Barre nursing home is not scheduled for construction funding consideration until FY 1993 at the earliest. Therefore, we will proceed with working drawing design of this project at a time closer to when construction funding is scheduled.

Question: 7. Are you aware of the following information?

- o The current 120 bed nursing home care unit at the Wilkes-Barre hospital is operating at full capacity.
- o There are 225 veterans on the waiting list to get into the unit, and some have been waiting as long as two years. The number of vets seeking admission has grown steadily since the facility was opened in July, 1982, and the need for nursing home beds in the region is expected to continue to grow.
- o The hospital does not have beds available for conversion to nursing home use.

Answer: -The 120 bed NHCU at VA Medical Center, Wilkes-Barre had the following statistics September 30, 1986:

The occupancy rate was 96.7% and

The waiting list contained names of 224 veterans: 40 service-connected and 184 nonservice-connected.

-The medical center does not have the space available to convert for nursing home beds. Construction needs related to patient privacy and expansion of the ambulatory care program will utilize all existing space.

Question: 8. Have you studied the possibility of taking state hospitals which are being abandoned in Pennsylvania -- such as state hospitals in Scranton, Nanticoke, and Hazleton -- and through leasing or purchase, bringing these beds into the VA system? If this question has not been studied, I would appreciate the VA looking into the cost-effectiveness of such acquisitions.

Answer: VA policy regarding the acquisition of property, such as the hospitals referred to, requires that prior to purchase or lease, an in-depth study be conducted to determine how the medical care needs of veterans in that particular area are being met. Planning guidelines for each medical district require that a veterans medical care needs assessment be conducted on an annual basis. To date, those assessments have shown that the hospital inpatient medical needs of veterans in Pennsylvania can be met through existing VA facilities. In other areas of the country, cost-effectiveness studies of acquiring unused non-VA hospitals has shown that because of stringent legislated requirements concerning space, materials, etc., it is usually more cost-effective to construct new VA owned facilities.

HON. BOB DORNAN TO VA

Question from House Veterans' Affairs Committee
FY 88 Budget Hearing
Honorable Bob Dornan

Question: National Security Directive (NSDD) 145 is currently the operative policy document relative to the protection of U.S. Government sensitive data. National Telecommunication Information System Security Policy (NTISSP) Number 2, dated October 20, 1986, provides a clear definition of "Sensitive Government Information" which includes the type of financial, personnel, benefit and medical information which will be transmitted on the VA Integrated Data Communication Utility (IDCU). Recognizing the potential cost implications of such measures, what are VA's plans for complying with these directives?

Answer: The VA is aware of the responsibilities mandated by these directives and policies as they pertain to the protection of sensitive government information transmitted on the IDCU and of the possible cost implications of meeting these responsibilities. The planning for the security of the IDCU is accomplished in accordance with the VA's overall ADP and telecommunications planning. As we gain experience with the implementation of these National directives and with the consequent refinements which may be required to ensure the protection of sensitive information in our automated systems, we might well find that additional funding will be needed to provide necessary safeguards. However, at this time we cannot definitively assess the financial implications of this.

As part of the VA's continuing efforts to ensure the protection of IDCU transmitted information, we have been, and are requesting and incorporating guidance from other government agencies with expertise in this area, such as the National Computer Security Center (NCSC). Having had the opportunity to review and respond to the initial draft of the IDCU Request for Comments (RFC), the NSCS indicated that "The security requirements are good, but, are spread across several sections." Accordingly, the security requirements are currently being consolidated into one security subsection of the soon to be released RFP. Also, in their suggestions, the NCSC recommended that "the IDCU meet a Class (C2) Controlled Protection Level to insure the separation and protection of the user and data." This suggestion has also been incorporated in the RFP for the IDCU.

When issued, the RFP will address other relevant personnel, physical and transmission security factors related to the protection of sensitive information.

HON. LANE EVANS TO VA

CONGRESSMAN LANE EVANS

QUESTION 1: P.L. 99-576 requires the Administrator to submit by March 1, 1987, a plan and schedule for the colocation of at least 7 regional offices on the grounds of VA medical centers. According to the proposed budget, "The VA is reviewing the colocation of various regional offices onto the site of the medical center nearest the facility. Future colocation projects at medical centers will be proposed whenever they are demonstrated to be cost effective."

QUESTION 1A: How many colocations are currently being reviewed by the VA?

RESPONSE 1A: Ten, with an additional six in the data gathering stage of development. Future plans call for nine more evaluations to be conducted as resources can be assigned for a total of twenty-five possible colocation projects evaluated.

QUESTION 1B: What are the results of the analysis of cost effectiveness of these colocations?

RESPONSE 1B: At this time it is too early to generalize. The cost-effectiveness of a given project is dependent on a large number of variables. Not all projects appear to be cost-effective. The specific results will be forwarded to the Senate and House Veterans' Affairs Committees by the Administrator of Veterans Affairs as soon as possible.

QUESTION 1C: How much time is required to prepare an analysis of the cost effectiveness of a colocation?

RESPONSE 1C: A 30-day period is generally allotted to prepare an economic cost analysis. This period permits field data gathering, compilation, computation and evaluation of results by the respective Departments involved.

QUESTION 1D: Will the plan and schedule for 7 colocations required by P.L. 99-576 by submitted on or before March 1st as required?

RESPONSE 1D: The report fulfilling the requirements of P.L. 99-576 is being reviewed by the Administrator's staff. The report will be forwarded immediately upon completion of the review.

QUESTION 1E: What is VA policy regarding colocation?

RESPONSE 1E: The VA policy on colocation of regional offices onto medical center grounds is one rooted in our overall commitment to providing our best talents and efforts to the service of the Nation's veterans and their beneficiaries. In this regard, we view colocation as offering the possibility to improve, in a cost-effective manner, the management of our resources, assist in the control and management of other Government resources, (through the elimination or reduction of housing costs administered through the General Services Administration), and upgrade our service delivery to our clients.

CONGRESSMAN EVANS

Question: 2. For next fiscal year, the VA is requesting $6 million to reactivate the Health Professional Scholarship Program. For the current fiscal year, the VA requested no funding for this program.

2.A. Has the scholarship program proven effective in the past in recruiting nurses?

Answer: Yes, the scholarship program has proven effective in recruiting nurses. Of the 378 full-time scholarship participants who have completed their required service obligation, 277 or 73% remain employed by the VA. All of the 43 part-time scholarship participants who have completed their service obligation remain employed by the VA.

Question: 2.B. What factors were responsible for the Administration requesting no funds for the nursing scholarship program in last year's budget?

Answer: No funds were requested in the Fiscal Year 1987 budget due to constrained resources and indications that the nursing shortage was abating. In Fiscal Year 1988, recruitment difficulties for nursing and physical therapy staff in some VA medical centers are significant enough to warrant requesting resources to support the Health Professional Scholarship Program even though resources remain constrained.

Question 3: The budget proposed $480,000 in payments next year to contractors for debt collection activities. Recently, I received some information on the activities of these contractors who are known as PCAs or private collection agencies. A private collection agency under contract to the Federal government billed a veteran for nearly 100% more than the amount the veteran owed the VA. The veteran has a principal debt of $1,515.50 and the private collection agency attempted to collect $2,930.38 from the veteran.

Question 3A: What is the nature of the relationship, if any, between the amount which a PCA attempts to collect from a veteran because of a debt to the VA and the amount of the debt principal? How and by whom is the amount sought by the PCA determined?

Response 3A: The VA referred debts to PCA's which could have been a combination of principal, interest, administrative collection costs, court costs or marshal fees. The PCA's, under the GSA contract, receive a percentage of what they collect of the total debt referred as payment for their services. This percentage is determined by the GSA contract based on the dollar amount of the debt.

Question 3B: How many debts to the VA have been contracted for collection by PCAs? How many debts to the VA have actually been collected by PCAs?

Response 3B: The VA referred approximately 350,000 accounts valued at $425 million (which included interest and administrative costs) to private collection agencies. Collections to date total approximately $3 million.

Question 3C: For debts to the VA which have been collected by PCAs, what was the total amount of principal debt to the VA; how much of the total amount collected by PCAs was received by the VA?

Response 3C: The amount of principal debt to the VA was approximately $417 million. Total collections are approximately $3 million. Of that figure, the VA received approximately $2.4 million.

QUESTIONS OF HONORABLE LANE EVANS

4: In January, there were many reports in the news about increasing the sale of federal assets. P.L. 99-576 prohibits the Administrator from taking any action to declare as excess certain lands at Sepulveda and West Los Angeles VA Medical Centers before January 1, 1988.

QUESTION 4A: Will any VA assets be considered or proposed for sale by the VA or any other federal agency during this fiscal year or next fiscal year? If yes, please provide specifics.

RESPONSE 4A: The VA is reviewing four parcels of land for potential excessing in fiscal year 1987. They are:

North Chicago, IL - 1.9 acres

Phoenix, AZ - .25 acres

White City, OR - 2.4 acres

Minot, ND - 20.6 acres

The VA is planning to excess to GSA certain lands at the Sepulveda (32 acres) and West Los Angeles (80 acres) Medical Centers in accordance with PL 99-576. In May of 1986, the Administrator issued a report which modified the excessing proposal contained in the 1987 budget (which called for the sale of 46 acres at Sepelveda and 109 acres at West Los Angeles). This report certified that excessing these properties would not limit current or future VA plans at these medical centers. In particular, the 80 acres of land proposed for excessing at West Los Angeles is less than half of the original 165 acres of unused or underutilized land identified in the original GSA survey.

QUESTION 4B: What is the policy of the VA regarding asset sales?

RESPONSE 4B: The VA does not have the authority to sell land under its control. The VA reports land which is excess to its needs to GSA, which has the authority to sell property.

Excessing decisions made by VA are based on an analysis of agency requirements. No land is identified by the VA as excess without intensive study of our projected land use requirements. All excessing actions are fully assessed, personally reviewed by the Administrator, and fulfill the criteria of 38 U.S.C. 5022.

Congressman Lane Evans

Question 5. Recent news reports indicate that the Administration is taking from Peter to pay Paul. The Administration is transferring funds from various accounts, agencies, and Departments to pay for the federal employee cost-of-living increase which became effective in January.

Question 5A. Have any VA accounts been subjected to deferral, transfer, or similiar action in conjunction with the recent employee COLA?

Response 5A. No.

Question 5B. What is the cost of the COLA for VA employees?

Response 5B. The cost of the January 1987 civilian pay raise for VA employees for 1987 and 1988, respectively is $165,435,000 and $231,998,000.

Question 5C. How much of this amount is being absorbed by the VA?

Response 5C. In 1987, $88,145,000 in appropriated funds are being absorbed by the VA. There is no absorption of the cost for the 1987 civilian pay raise in 1988. The Agency is requesting an increase in the limitation for expenses of the Office of Facilities from $38,000,000 to $39,194,000, to cover the cost associated with the 1987 civilian pay raise and FERS. The $1,194,000 ($665,000 for pay raise and $529,000 for FERS) associated with this action is available within the 1987 Construction, minor projects appropriation.

Question 5D. How is it being absorbed?

Response 5D. The following is a breakdown by object class by program (dollars in thousands):

	Medical Care	Medical & Prosthetic Research	GOE DVB	GOE DMA	GOE Staff
Personal Services	...	...	$1,606	$276	$2,583
Travel	...	...	500	...	...
Rents, Communications & Utilities	$13,816	...	...	36	...
Printing	...	...	679	...	...
Other Services	14,155	$ 54	3,500	200	...
Supplies & Materials	46,725	1,583	300	...	...
Equipment	...	222	1,115	130	...
	$74,696	$1,859	$7,700	$642	$2,583

Absorption of these costs is based on a VA reassessment of budgeted versus latest estimates and is standard practice across the Federal government.

The Department of Veterans Benefits (DVB) was able to absorb part of the pay raise because of changes since the budget was formulated: including no insurance consolidation ($2.2 million), reassessment of contract requirements in State Approving Agencies ($500,000), and the shift of funding for fee appraisals to the Loan Guaranty Revolving Fund ($3.0 million). DVB reduced staff (36 FTE) and realigned resources to absorb the pay raise and to better manage resources to meet future FTE requirements.

The Department of Memorial Affairs was able to absorb $276,000 in personal services without affecting FTE because of a lower than projected average salary.

CONGRESSMAN EVANS

General Operating Expenses (GOE) Central Staff offices were able to accommodate the pay raise within their operating budgets primarily because FTE remained under plan through the first quarter thus making personnel dollars available for this purpose. FTE was lower than planned since budget constraints and hiring freezes during FY 1986 lowered FTE going into 1987; funding uncertainty because of beginning year continuing resolutions did not allow the rapid recovery planned.

Question: 6. What is the current status of the Women's Vietnam Veterans Epidemiology Study?

Answer: The Women's Epidemiology Study known as the "Health Study of Women Vietnam Veterans" will assist in determining the deleterious health effects, if any, of the Vietnam experience on the health status of women Vietnam veterans and also, appropriate treatment, if necessary, for conditions possibly related to that experience. A protocol for the conduct of this study is currently being prepared by an independent contractor, New England Research Institute, for the VA. It is expected that the protocol will be submitted to the VA by July 1987. The contract for the conduct of this study is anticipated to be awarded by December 1987. It is currently projected that this study will be completed on or about October 1989. The total estimated cost for the conduct of this study is $2,372,000.

Congressman Lane Evans

Question 7a. What is the amount of the difference, if any, between the budget which has been proposed by the VA for Fiscal Year 1988 and a current services budget for Fiscal Year 1988?

Response 7a. The attached spreadsheet is being provided to show the variance between the FY 1988 request and the current services budget. The request includes proposed legislation. Included on the spreadsheet are explanations of any variances. However, a more detailed explanation is required for Loan Guaranty Revolving Fund.

The 1988 budget request includes several initiatives designed to make the loan guaranty program solvent, improve credit management practices, and maintain the veterans access to low cost housing. These initiatives include: increasing the funding fee from 1 percent to 2.5 percent (if financed, this would increase the veteran's monthly payment by less than $10); begin selling the VA's loan portfolio (the budget anticipates the sale of $300 million in 1988); increasing the minimum percentage of properties sold for cash; and selling all loans without recourse. These initiatives would obviate the need for substantial appropriations while still maintaining the program's primary objective of providing the veteran an opportunity to purchase a house with no downpayment financing.

The following are the crosswalks for Medical Care and General Operating Expenses from the 1988 Current Services to the 1988 Budget Authority:

Bridge from 1988 Current Services to 1988 Budget Authority

Medical Care

		($ in thousands)
1988 Current Services	$	10,041,142
1987 Pay raise absorption	+	74,695
Funding reduction for Category C Veterans	-	167,186
New Initiatives:		
DHCP - Implementation and VAMC Savings (Net)	+	20,425
Motor vehicle reduction	-	1,805
CALM - VAMC Savings	-	260
Community nursing workload	+	7,287
NSEP telecommunications	+	115
VA domiciliary reduction	-	175
Wage grade demo project	-	320
CHAMPVA registry implementation and savings/workload reductions (Net)	-	5,318
Subtotal, new initiatives	+	19,949
All Other	-	992
1988 Budget Request	$	9,967,608

General Operating Expenses

1988 Current Services	$	764,849
New Initiatives:		
Modernization (DVB)	+	33,704
Pay raise for modernization (DVB)	+	686
Insurance consolidation (DVB)	+	1,177
GSA files initiative (DVB)	+	8,935
Contracting for services (DMA & Staff Offices)	-	1,621
ADP initiatives (DVB & Staff Offices)	+	6,699
Motor vehicle reduction (DMA & Staff Offices	-	513
Other non-payroll (DVB & DMA)	+	2,184
Subtotal, new initiatives	+	51,251
1988 Budget Request	$	816,100

Question 7b. If costs associated with activation of facilities during Fiscal Year 1988 were included in a current services budget for next fiscal year, what would be the amount of a current services budget for Fiscal Year 1988?

Response 7b. The following table provides a breakdown of the Medical Care Current Services total for FY 1988. The amount of $174,882,000 is provided for facility activations.

		Budget Authority ($ in thousands)
1987	Appropriation	$ 9,411,817
	HHS transfer	+ 10,395
	Pay raise supplemental	+ 74,695
	FERS Supplemental	+ 131,600
1987	Adjusted Base	9,628,507
	Activation & ADP prior year equipment	- 199,031
	Facility Activations	+ 174,882
	HBHC annualization	+ 740
	Meharry affiliation	+ 54
	Real property rental	+ 2,567
	DVB-CS transfer	+ 1,297
	Federal employees compensation	+ 5,728
	Workday change	+ 22,478
	Stipend	+ 8,950
	Social Security	+ 34,271
	Pay raise annualization	+ 135,500
	FERS annualization	+ 194,300
	Pay compensation reduction	- 8,712
	Inflation	+ 178,059
	One percent productivity increase	- 58,297
	HHS transfer	- 10,395
	VADATS reduction	- 2,502
	State Home and Calendar Day change	+ 6,449
	All other	+ 992
1988	Total Current Services, unadjusted	$10,115,837
	Adjustment for reduction of program level related to 1987 pay absorption pursuant to OMB Circular A-11, Sec. 27.2 (b) (5)*	- 74,695*
1988	Adjusted current services	$10,041,142

*Absorption of pay raises reduces the non-payroll spending and thereby lower the current services base throughout the projection period.

FY 1980 Request and Current Services Estimates
(Dollars in Thousands)

	Budget Authority	Current Services	Variance Current Services Request	Explanation of Variance
Compensation 1/	10,653,000	10,653,000	0	
Pensions	3,840,600	3,840,600	0	
Burial Benefits 1/	106,137	141,687	35,550	Proposed legislation $-31.3 million to standardize eligibility for plot allowance; transfer funding of Veterans Mortgage Life Insurance to VI&I
Readjustment Benefits 1/	605,300	625,700	20,400	Proposed legislation authorizing DoD to budget for all benefit costs associated with the New GI Bill
Veterans' Job Training	0	0	0	
Reinstated Entitlement Program	0	0	0	
Veterans Insurance & Indemnities 1/	18,540	14,290	(4,250)	Proposed legislation authorize to fund the Veterans Mortgage Life Insurance program
Loan Guaranty 1/	0	320,000	320,000	Explanation made in response to question 7a
Direct Loan	0	0	0	
Service-Disabled Insurance	0	0	0	
Veterans Reopened Insurance	0	0	0	
Education Loan 1/	0	0	0	
Voc Rehab Revolving Fund	0	0	0	
Servicemen's Group Life	0	0	0	
Total, Benefits	15,223,577	15,595,277	371,700	
Medical Care	9,967,608	10,041,142	73,534	Explanation made in response to question 7a
Medical & Prosthetic Research	198,766	198,766	0	
MAMOE	49,840	42,790	(7,050)	$6 million for Health Professional Scholarship; $1 million contract for collection of mortality & morbidity data
Grants for Construction SECF	42,000	43,004	1,004	Inflation factor
Grants to Philippines	500	500	0	
Special Therapeutic	0	0	0	
Assistance Health Manpower	0	0	0	
Canteen Service	0	0	0	
Total, Medical	10,258,722	10,327,090	68,368	
Construction, Major	400,556	398,016	(2,540)	The mix of projects varies from year to year and a straight comparison
Construction, Minor	121,038	83,707	(37,331)	in "Capital Budgeting" cannot be explained on the same basis as an
Parking Garage	4,100	31,200	27,100	operating budget.
Total, Construction	525,694	512,923	(12,771)	
General Operating Expenses	816,100	764,849	(51,251)	Explanation made in response to question 7a
Grants for State Vet Cemeteries	0	0	0	
Supply Fund	0	0	0	
TOTAL, FEDERAL FUNDS	26,824,093	27,200,139	376,046	
Trust Funds				
PVEVEA	201,860	201,860	0	
General Post	15,000	15,000	0	
National Service Life	1,375,100	1,375,100	0	
US Government Life	15,520	15,520	0	
Veterans Special Life	0	0	0	
Total, Trust Funds	1,607,480	1,607,480	0	
Receipts (Includes GI Bill) 1/	(717,310)	(939,183)	(221,873)	Proposed legislation for Servicemembers' contributions into the New GI Bill to DoD
Interfund Transfers	(138,902)	(138,902)	0	
TOTAL, VETERANS ADMINISTRATION	27,575,361	27,729,534	154,173	

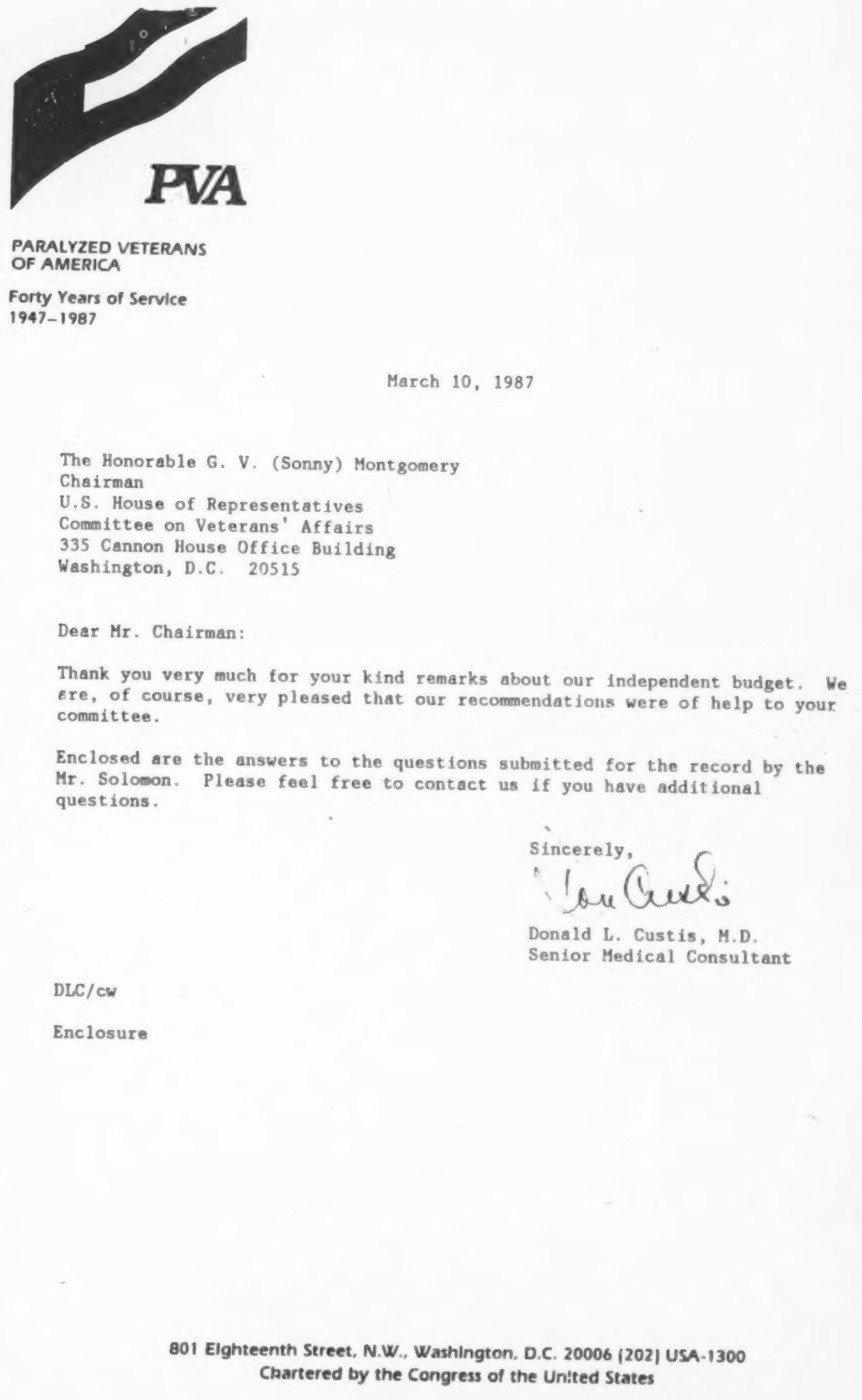
1/ Includes proposed legislation

CONGRESSMAN LANE EVANS

QUESTION 8: The budget proposes a further significant reduction in average employment in the Department of Veterans Benefits. Many people are concerned the reduction in DVB personnel means a deterioration in the timeliness and quality of benefits and services provided to veterans. Please respond to these concerns, providing statistical data when appropriate.

RESPONSE 8: The proposed reduction of 296 in average employment includes modernization savings of 117 FTEE. The balance of 179 FTEE is associated with the workloads. Based on past trends, it is expected that there will be some productivity increase in 1988. We do not anticipate that there will be any specified declines in timeliness and quality from the current service level. The FTEE level requested in the 1988 budget will provide continued good service to our veteran population.

HON. GERALD B.H. SOLOMON TO PVA



PVA

PARALYZED VETERANS
OF AMERICA

Forty Years of Service
1947–1987

March 10, 1987

The Honorable G. V. (Sonny) Montgomery
Chairman
U.S. House of Representatives
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you very much for your kind remarks about our independent budget. We are, of course, very pleased that our recommendations were of help to your committee.

Enclosed are the answers to the questions submitted for the record by the Mr. Solomon. Please feel free to contact us if you have additional questions.

Sincerely,

Don Custis

Donald L. Custis, M.D.
Senior Medical Consultant

DLC/cw

Enclosure

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300
Chartered by the Congress of the United States

Questions for FY 88 Budget Hearing from Honorable Gerald Solomon

1. What is the effect of using equipment money in the Department of Medicine and Surgery to finance pay raises and retirement programs?

> The VA backlog of equipment is growing and has become excessive. According to some tallies, this backlog exceeds one-half billion dollars. The equipment account has borne a disproportionate share of costs and we know that in some cases the VA is using outmoded equipment. We would also point out that inadequate funding for equipment resulting in use of outmoded equipment means the VA is prevented from providing up-to-date medical care in at least some instances. The problem is compounded by the VA's "useful life time" schedules for equipment that do not adequately reflect technological obsolescence as a factor in the need to replace equipment.

2. What is the actual amount of additional money which you feel should be added to the medical Budget?

> Six hundred ninety-two million dollars ($692) in additional funding should be added to the Administration's 1988 appropriations level for all medical programs (total Department of Medicine and Surgery). This includes an additional $657 million for the medical care account, $16.7 million for Medical and Prosthetic Research, $126,000 for MAMOE and $18 million for Grants for Construction of State Extended Care Facilities. The Independent Budget also recommends that an additional $180 million be added to construction funding for twelve nursing home units.

3. Have other groups or associations endorsed your suggested budget? If so, who are they?

> The following groups have endorsed the Independent Health Care Budget for Veterans:
>
> American GI Forum
> American Health Planning Association
> American Ex-Prisoners of War, Inc.
> Blinded Veterans Association
> Catholic War Veterans of the USA, Inc.
> Jewish War Veterans of the USA
> Military Order of the Purple Heart of the USA
> National Association of VA Physicians
> American Nursing Association

4. Please comment on the new proposed mix of VA nursing home beds (30%), contract nursing beds (40%), and state home beds (30%)?

> Plans made using this new proposed mix (VA Nursing Home--30%, contract nursing beds--40% and state home beds--30%) assume that major expansions in available state and community nursing home places will occur. We are skeptical. Largely as a Medicaid cost control device, some 15 states have frozen construction of new nursing homes within their borders. In this climate, availability of more places for VA-sponsored patients is questionable. Any increase in VA census is likely to require displacing non-VA patients, which could create strong resentments in the community. Moreover, an increase in VA census is likely to create a bidding war against Medicaid, with the likely result being higher costs to the federal government for both Medicaid and VA health care. Some states have not been eager to accept VA's construction subsidies for State veterans nursing homes, since most of the cost of operating these State homes falls upon State budgets. Thus a major increase in the capacity of State veterans nursing homes seems very doubtful. In the long-term, then, we advocate a mix of 40% VA nursing home places, 35% community places, and 25% State home places. And we do so recognizing that the projections for non-VA places may still be overly optimistic. However, it should be noted that in the short-term, expansion must come primarily in the community nursing home program because of time constraints for construction of VA nursing homes.

5. Does your proposed budget ask for additional money for beneficiary travel? If so, how much and how should it be spent?

An additional $90 million was proposed in the Independent Budget for patient travel which would bring the total for patient travel to $100 million. The Independent Budget recommends that $40 million be included in the FY 1988 medical care appropriation as an item covering only reimbursement to veteran patients for their out-of-pocket travel expenses to and from VA medical clinics and hospitals. We recommend the term "beneficiary travel" be restricted as referring only to this type of travel reimbursement. A separate and distinct $60 million should be included in the appropriation specifically for interfacility transfer of patients.

Although the Administration's budget claims that it contains $50 million for beneficiary travel, only $10 million was appropriated for this purpose. However, the additional $40 million is the result of 1987 reprogrammings from capital investments which became part of the base for beneficiary travel. We recommend replacement of this capital investment money back in the capital investment account. This would, therefore, leave only $10 million for beneficiary travel.

If patient travel reimbursement is markedly reduced or eliminated, the need for fee basis private medical care will increase as beneficiaries with entitlement for this care cease traveling to VA facilities. This increased care cost is likely to be much larger than savings in travel reimbursements. As well, there would be some veterans who would lose all access to medical care.

Chairman Montgomery to Dr. Howard Green

Medical and Regional
Office Center
White River Jct. VT 05001

Veterans
Administration

March 12, 1987

Honorable G. V. (Sonny) Montgomery
House of Representatives
Chairman, Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

In Reply Refer To: 405/11

Dear Mr. Montgomery:

Thank you for your letter of February 25. The following are the answers to your questions:

1. Are you aware of verbal or written instructions sent to the field to the effect that payment of special salary rates could be implemented, but must be paid out of existing funds at each hospital?

Ans: Yes. MP-4, Part 7, Para. 3A.10b, states specifically that "facilities are expected to fund 100% of total". In addition, this has been reinforced repeatedly in conferences, meetings with the Regional Directors and in practice.

2. How have new activations of VA medical facilities affected your hospitals in terms of staff resources?

Ans: It is common knowledge that an attempt is made with new activations to provide optimum staffing. In the last several years, activations FTE have come from the existing system pool. This has necessarily resulted in loss of staff among those who contribute to the activation pool. In general, the Resource Allocation losers have been the contributors to this pool.

3. Budget constraints and the lack of a VA-wide plan for advanced medical equipment have constrained the acquisition of state-of-the art technology. In some cases, this has forced VA medical facilities to rely on transporting patients to VA facilities which have the needed equipment or to private sector or DOD facilities. Please describe the adequacy of funding for such transportation and relate it to the proposed $50 million for beneficiary travel for fiscal year 1988.

Ans: I have no data on whether or not $50 million would be sufficient to meet the need for transportation of veterans to obtain special high technology diagnostic or therapeutic procedures. My intuition says it is not sufficient. These examples are offered. If funds are not sufficient to obtain procedures locally, we would have to arrange transportation to Boston for MRI, Radiation Therapy, Mammography, Lithotripsy. MRI's use is escalating, mammography has become a requirement on all women veterans and lithotripsy requirement is escalating. The cost per round trip at $.20/mile is $54.00, in addition to the cost of lost time for the patient. At this point, I cannot predict the total cost, but if funds for procurement of so-called hi-tech are limited, the problem will escalate in its importance.

"America is #1—Thanks to our Veterans"

4. Please describe to the Committee how outpatient visits are counted for purposes of resource allocation and the effect this procedure has on staffing in your hospital.

Ans: The outpatient model is quite complex for FY'87 allocation. The basis of determining the number of veterans who come to the facility for outpatient care was derived from a 20% sample of the outpatient routing sheet. A capitated amount was given to the facility based on the number of individual veterans seen. The capitation amount was determined by the specific profile of services used by the veteran. This profile consisted of five specific categories of use. Entry into each category was dependent upon achieving a specific threshold number of visits to clinics which had been classified as belonging to one of the five categories. Additional funds were received for special procedures such as CT scan, cancer chemotherapy, radiation therapy, blood and Blood Product, transfusion, Ambulatory Surgery and MRI, given to or performed on the veteran. Use of services were displayed by ages of veterans within each category and average visit rates were calculated for each age group. The amount received was determined by multiplying the number of people in each patient type and age group category by the national average cost per person for that age and patient type category. Other adjustments were made to the allocation if the facility visit rate exceeded the national average visit rate for a category multiplied by the number of patients in the category.

The effect of the system:

The system is susceptible to gaming because of threshold entry into specific categories, particularly Psychiatry. In addition, the definition of an ambulatory surgical visit was too diffuse and large amounts of money could be accrued for doing low-cost procedures. The net effect was that in our case we took a major loss in money in ambulatory care and unless we receive restoration, we will be forced to cut ambulatory care staff. The loss was due to model defects not actual productivity.

5. The proposed fiscal year 1988 budget reduces staff by 146 FTEE as a result of savings from the Decentralized Hospital Computer System improvements. How many FTEE have you received to operate and maintain the DHCP system and how many would you likely lose as a result of the proposed decrease in fiscal year 1988?

Ans: We have received no staffing for implementation of DHCP. Staffing for this activity was taken from existing staff, thereby reducing those available for direct patient care. I cannot relate the proposed 146 FTEE system loss to this hospital because I have no direct knowledge how the system would apportion the loss. The concept appears strange. In essence, Step 1 says create FTE from your existing pool to implement DHCP. Step 2 says now that you have become more efficient reduce your FTE further. Additional programs have created needs for FTE (means tests, medical records functions) rather than reduced them. The DHCP system has reduced the number of additional FTE needed.

6. I understand that the new quality assurance programs will rely heavily on the DHCP system. How many extra FTEE have you received to staff this function?

Ans: None, yet we have been told to take two more FTE from our in-house ceiling to serve this function.

7. What is the percentage of Category C veterans applying for care at your facility and how would the effectiveness and efficiency of your facility be affected if funds for Category C veterans were eliminated from your budget?

Ans: We have 7.9% Category C patients applying for care. As I stated in testimony, if monies were removed in proportion to the percentage, our facility would lose greater than 100 FTE over a three-year period. In effect this would create a mission change. We could not sustain current programs with this kind of loss because the loss would have to come from those people who directly care for or directly support care of veterans. Losses could not come from indirect cost services because these services are part of the fixed cost of keeping the facility open.

8. How would you implement the proposed reduction of Category C funds and how would it be possible to prevent adverse consequences to Category A and B veterans?

Ans: I would cut out all programs which by their removal would not jeopardize our ability to deal with acute life threat to veterans. The services removed would include, but not be restricted to Alcohol Rehabilitation, HBHC, Nursing Home Care, ENT, Ophthalmology, Plastic Surgery, Endocrinology, Fire Department, Nursing Education and Ambulatory Care staff. This would not be sufficient to account for the personnel loss required. It would not be possible to prevent adverse consequences to Category A and B veterans. While the Category A, B, C classification has administrative meaning, it has little relevance to the medical needs of veterans applying for care.

9. Is there a penalty, in terms of the RAM model, for providing care to Category C veterans or those that the Administration refers to as "low priority" veterans?

Ans: The RAM model per se appears to be neutral on the issue of veteran priority. However, as part of the total allocation process a penalty was assessed for treating non-service connecting veterans not in receipt of pension. In the case of our facility, this penalty was 29 FTE reduction in our initial target allowance. This has been subsequently restored.

10. The Committee has heard that Gramm-Rudman-Hollings cuts are still routinely taken out of medical center target allowances. Is that true?

Ans: No. There was an initial one year FTE reduction triggered by Gramm-Rudman-Hollings. This reduction is a permanent reduction in ceiling and is therefore recurring.

11. Please describe to the Committee the restrictions on FTEE for research in the VA and what effect those restrictions have on the ability of the VA to continue its significant contributions.

Ans: The principle problem is that of FTE ceilings. By their very nature, research grants obtained through the VA Merit Review process are time limited. This necessitates that the bulk of research personnel hired carry term or temporary appointments. The research service is bound however, by an assigned FTE ceiling. We have found ourselves in the position of having funds to do research yet no FTE to do the project. The solution to the problem is to exempt research from FTE ceilings on all employees who are hired on a term or temporary basis. The nature of funding makes the number of FTE self-regulating.

Sincerely yours,

HGreen

HOWARD H. GREEN, M.D.
Chief of Staff

CHAIRMAN MONTGOMERY TO MR. C. WAYNE HAWKINS

MAR 28 1987

Medical Center

4500 South Lancaster Road
Dallas TX 75216

Veterans
Administration

MAR 28 1987

March 23, 1987

In Reply Refer To: 549/00

Honorable G. V. (Sonny) Montgomery
Chairman, U.S. House of Representatives
Committee on Veterans' Affairs
235 Cannon House Office Building
Washington, DC 20515

Dear Mr. Montgomery:

As requested in your letter dated February 25, 1987, enclosed are my answers to the additional field panel questions as part of the hearings on the FY 1988 VA budget. Please let me know if I can provide any additional assistance.

Sincerely,

C. WAYNE HAWKINS
Medical Center Director

FIELD PANEL:

1. Are you aware of verbal or written instructions sent to the field to the effect that payment of special salary rates could be implemented, but must be paid out of existing funds at each hospital?

On a recent VACO Fiscal Service nationwide conference call it was stated that any special rate approved after December 4, 1986 would "be considered" for funding on a case-by-case basis. In order to compete with other agencies and private industry in the Dallas area, it was a necessity to participate in a recent "Salary Survey for Clerical Employees" which, when implemented, will cost our Medical Center approximately $300,000. No funding from VA Central Office is available at this time for implementation. Our formerly implemented special rate schedules for Pharmacy and Nursing, which amounts to approximately $90,000 per year additional costs, would still have to be absorbed inasmuch as they were implemented prior to December 4, 1986.

2. How have new activations of VA medical facilities affected your hospitals in terms of staff resources?

In FY 1986, facilities who would have gained money because of the application of the Resource Allocation Methodology (RAM "winners") had their "winnings" taken to fund activations within the VA system. Our share would have been $1,398,227 in recurring dollars which we did not receive. We have had several small activations of programs within the last several years which were supported with resources.

3. Budget constraints and the lack of a VA-wide plan for advanced medical equipment have constrained the acquisition of state-of-the-art technology. In some cases, this has forced VA medical facilities to rely on transporting patients to VA facilities which have the needed equipment or to private sector or DOD facilities. Please describe the adequacy of funding for such transportation and relate it to the proposed $50 million for beneficiary travel for fiscal year 1988.

The Dallas VAMC has been forced to rely on transporting patients to other VA facilities or to the private sector. The Medical Center within the last two years has provided funds in the following manner:

a. Air Ambulance - $24,548.00. Used to transfer spinal cord injury patients and burn patients.

b. Commercial Air - $6,635.00. Used to transport heart transplant patients (both pre-op and post-op) and post traumatic syndrome patients.

c. Taxi Deliveries - $47,969.00. Used to deliver certain specimens to private sector institutions for testing and to transport patients requiring special treatment.

d. Ground Ambulance - $7,920.00. Used to transport patients to the medical school for special evaluation and NMR tests.

Substantial beneficiary travel program cuts were planned for implementation earlier this fiscal year (FY 1987). In anticipation of these program reductions our beneficiary travel funds were reduced by VACO, but the target date for implementation has slipped to the point that we have expended virtually all of the travel funds allocated for this fiscal year with more than one-half year still to be funded.

Depending upon the travel resources provided to us in FY 1988, the continued transfer of patients for services which we cannot provide because we lack particular items of equipment may create a situation in which we have to cut services in another area to support the travel.

4. Please describe to the Committee how outpatient visits are counted for purposes of resource allocation and the effect this procedure has on staffing in your hospital.

Outpatient visits are counted for the purpose of reimbursement through a very sophisticated computerized method. The methodology creates the need for increased staffing for data validation and administrative tracking to assure workload capture. It is of utmost importance that all visits and clinic stops get credited into the Decentralized Hospital Computer Program (DHCP), otherwise reimbursement is lost for work performed and the facility has to operate two years later with a decreased budget. Also complicating this scenerio is the fact that the demand for outpatient services are increasing.

Overall the administrative demands for correct and complete workload documentation have increased dramatically due to the outpatient reimbursement methodology. Despite the increase in administrative demand, no additional FTEE have been granted to support it.

5. The proposed fiscal year 1988 budget reduces staff by 146 FTEE as a result of savings from the Decentralized Hospital Computer System improvements. How many FTEE have you received to operate and maintain the DHCP system and how many would you likely lose as a result of the proposed decrease in fiscal year 1988?

The Dallas VA Medical Center has not received any FTEE to operate and maintain the DHCP System. If the reductions occur as proposed we would anticipate losing at least one (1) FTEE from our current ADP staff which is already not capable of providing all of the support we need or are being asked to provide, particularly for clinical applications.

6. I understand that the new quality assurance programs will rely heavily on the DHCP system. How many extra FTEE have you received to staff this function?

No additional FTEE has been received to staff the new Quality Assurance Program which will impact heavily on the DHCP System.

7. What is the percentage of Category C veterans applying for care at your facility and how would the effectiveness and efficiency of your facility be affected if funds for Category C veterans were eliminated from your budget?

Since July 1, 1986, the Dallas VAMC processed 9,021 nonservice-connected veterans for means testing. Approximately 540 or 6% are Category C veterans. If operating funds are reduced because Category C patients are eliminated it will cause a loss in support funding and/or staff, subsequently reducing Medical Center effectiveness and efficiency. We do not have a designated segment of our resources set aside to accommodate Category C patients. Any cuts made would be across the board and would affect our ability to care for all patients, including Category A and B veterans.

8. How would you implement the proposed reduction of Category C funds and how would it be possible to prevent adverse consequences to Category A and B veterans?

All Category C veterans would have to be told no VA resources are available to treat them. Only emergency humanitarian care would be rendered to Category C patients; e.g., motor vehicle accident, heart attack, etc. There is no way to avoid adverse consequences to Category A and B patients because a reduction in resources and staffing would affect our ability to care for all patients.

9. Is there a penalty, in terms of the RAM model, for providing care to Category C veterans or those that the Administration refers to as "low priority" veterans?

No. The current RAM Models treat and reimburse all veterans exactly the same, regardless of eligibility, means test or priority.

10. The Committee has heard that Gramm-Rudman-Hollings cuts are still routinely taken out of medical center target allowances. Is that true?

The Administration's initial FY 1987 VA Budget submission contained a substantial workload reduction and corresponding funding decrease for all VA facilities. When the actual budget was passed by Congress, the workload reduction was restored, but only a percentage of the funding was returned. We lost $1,009,864 by not receiving full restoration of funds. It is my understanding that the reductions were originally predicated upon meeting the requirements of the Gramm-Rudman-Hollings goals.

11. Please describe to the Committee the restrictions on FTEE for research in the VA and what effect those restrictions have on the ability of the VA to continue its significant contributions.

Congress allocates FTEE annually to the VA Research and Development Service nationwide at a level insufficient to support the planned and funded VA Merit Reviews, Research Advisory Group awards, Career Development awards, and VA Cooperative Study proposals. When such awards are made, the Merit Review Boards make a recommendation of the FTEE that will be required for the successful execution of each award. The problem that develops is that insufficient FTEE is available by Congressional approval to accommodate the Merit Review Boards' recommendations. Therefore, each Medical Center is given a diminished allotment of FTEE which is insufficient to hire those technicians and other research personnel necessary to accomplish the approved and funded research.

In an effort to compensate for this insufficient supply of FTEE, investigators often find it necessary to contract out work; a less cost effective alternative to employment due to the high overhead operational costs charged the VA by other organizations receiving VA contracts. Investigators hire Work-Study Program participants (students) as an alternative to permanent qualified employees in an effort to save employment ceiling. Such students have limited hours of eligibility and have a rather consistently high turnover rate. Investigators find such students of diminished worth to research programs requiring highly developed skills for complex methodology.

CHAIRMAN MONTGOMERY TO DR. RALPH S. GOLDSMITH

Medical Center

4150 Clement Street
San Francisco CA 94121

Veterans
Administration

MAR 13 1987

March 11, 1987

In Reply Refer To: 662/11

Honorable G.V. (Sonny) Montgomery
Chairman
Committee on Veteran's Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for the extraordinary opportunity that you provided to me, Dr. Green, Mr. Hawkins, and Ms. Halley to represent the view of our colleagues from VA Medical Centers on FY 88 budget issues. There is no question in my own mind that you, the Members, and Staff of the Committee are sincerely interested in meeting the needs of our veteran clientele, which we all endorse and for which we are grateful. I could not be more delighted with the reception that you gave us. Obviously I am particularly pleased about your comments and actions regarding AIDS.

I enclose my responses to the additional questions that you posed. I fear that I became somewhat long-winded in some of my answers, but I feel so strongly about the issues that I threw restraint out the window.

Thank you very much.

Sincerely,

Ralph S Goldsmith

RALPH S. GOLDSMITH, M.D.
Chief of Staff

"America is #1—Thanks to our Veterans"

1. Q. Are you aware of verbal or written instructions sent to the field to the effect that payment of special salary rates could be implemented, but must be paid out of existing funds at each hospital?

A. Yes, we were told that requests for special salary rates would not even be accepted unless a statement were included that the Medical Center could handle the increased costs out of existing funds. This has been codified in the VA Manual, DM&S Supplement, MP-4, Part VII, 3A.10b. which states "Facilities are expected to fund 100 per cent of the total cost."(see Appendix 1) In practice, however, this has not been absolute; VACO through Bob Lindsey has recognized the impossibility of meeting the extraordinary amount of funds needed in some cases and has been able to assist those Medical Centers with the greatest problem.

2. Q. How have new activations of VA medical facilities affected your hospitals in terms of staff resources?

A. It is very difficult for me to assess any direct coupling between new activations and staff resources at other Medical Centers. The only coupling of which I am aware is that the expenditures for new activations obviously reduce the number of dollars that could be made available for RAM calculations, thus reducing the dollar value per weighted workload unit and therefore the funding of direct medical care. Since the funds in turn determine FTEE, there is necessarily some indirect effect, but I cannot state its magnitude.

A related facet is that activations are usually staffed at a higher rate than existing facilities, so that more resources are withdrawn from the pool than might be justified by anticipated workload. This actually introduces an interesting dilemma for those facilities receiving such activation resources, namely, the fact that their subsequent workload will not support the added resources. Therefore, over the course of subsequent years, they will be in negative balance according to the RAM (i.e., expenditures will exceed earnings), with progressive loss of those resources. The net result of this sequence, then, is a brief peak of resources including FTEE followed by a long and inevitable decline.

3. Q. Budget constraints and the lack of a VA-wide plan for advanced medical equipment have constrained the acquisition of state-of-the-art technology. In some cases, this has forced VA medical facilities to rely on transporting patients to VA facilities which have the needed equipment or to private sector or DOD facilities. Please describe the adequacy of funding for such transportation and relate it to the proposed $50 million for beneficiary travel for fiscal year 1988.

A. At the San Francisco VA Medical Center, 34.5% of special mode travel was expended for special contract care, i.e., for transporting patients to other VA, DOD, and private facilities for special procedures and/or consultations. Since VAMC San Francisco is relatively well-equipped with state-of-the-art technology for a VA facility and is staffed with high-expectation personnel, it can be reasonably assumed that it uses proportionately fewer funds than most VA Medical Centers for transportation to other facilities. Therefore, a significant fraction of the funds for special mode travel throughout the VA must be employed for transportation to other facilities, perhaps as high as 50%. If the VA were to fall further behind the private sector in availability of high technology, it seems likely that an even higher fraction of funds would be required for this purpose. Certainly if this were coupled with loss of critical personnel or inability to recruit and retain personnel in high demand, the problem could be much worse.

It is probable that the projected $50 million for special mode beneficiary travel for FY 1988 will be sufficient if we can maintain our present status. However, at San Francisco, continuing problems with staffing of nurses, pharmacists, and technologists because of pay inequities is already causing increased expenditures for transfer or diversion of veterans to other facilities. Unless we are able to improve our staffing pattern, funds for special mode travel will be eroded rapidly. I realize that this portion of my response is moving slightly off the main track, but it does impact the availability of funds.

4. Q. Please describe to the Committee how outpatient visits are counted for purposes of resource allocation and the effect this procedure has on staffing in your hospital.

A. The number of outpatient visits is used with cut-points to determine the number of dollars funded per patient. The major cut-point is six visits per year, with increased funding for each patient who has more than that number. In the case of psychiatric visits, the cut-point of six visits represents an increase of funding to $3000 per patient. This introduces three artificial facets to the funding. The first is a result of the fact that the VA counts a "visit" as being equivalent to one day. Therefore, a patient who may go to three separate clinics ("stops") in any given day is considered as having had one visit. If s/he did each of those three clinic stops on three successive days, it would be counted as three visits. However, with the exception of travel, costs to the Medical Center are identical whether the three stops are on the same or different days, but the Medical Center loses credit for workload if there are multiple stops in one day. The second artificiality is that there seems to be no magic in six visits, yet having such a cut-point will stimulate all Medical Centers to aim for a minimum of seven visits per patient per year whenever possible. Since additional visits beyond this number are funded at half the regular rate, it is clear that seven visits may be viewed as a maximum as well. This is one of the clear hazards of having a medical care system driven by economics rather than quality of care. The third is that, with the exception of psychiatric visits, there is no recognition of the differences in cost of different types of clinic visits. It must be obvious that a patient visit for hypertension check-up is less costly than a visit of a patient with congestive heart failure under marginal or poor control.

The major effect of these artificialities is that loss or gain of staff has too little relationship to actual workload. Imputed workload based on the existing model will ultimately determine FTEE, but actual workload may be very different. As we try to make patient care more convenient and less taxing for the patient by consolidating multiple clinic visits on a single day, we damage our recognized workload figures and ultimately risk the loss of FTEE. This kind of conflict between quality of care and fiscal "reality" is unacceptable.

5. Q. The proposed fiscal year 1988 budget reduces staff by 146 FTEE as a result of savings from the Decentralized Hospital Computer System improvements. How many FTEE have you received to operate and maintain the DHCP system and how many would you likely lose as a result of the proposed decrease in fiscal year 1988?

A. We have never received any FTEE to operate and maintain the DHCP. All the personnel that we have put into this role have come from FTEE assigned elsewhere in the Medical Center.

It must be pointed out that the DHCP, or any other similar computer-based hospital information system, does not save FTE. In most cases, it simply provides a mechanism for more efficient handling of patient data, thereby contributing positively to the quality of patient care. Since the amount of patient data is always increasing as a result of new technology and more dependence upon laboratory, x-ray, ultrasound, MRI, etc., the availability of computers permits Medical Centers to handle these data better. If there is any effect on FTE, it is only to slow the need for additional growth to meet patient data requirements.

A clarification is perhaps indicated with regard to FTEE for the DHCP. To my knowledge, the only FTEE provided for DHCP were assigned to the Regional Information Service Centers, originally called Verification and Development Centers. Quite large numbers of FTEE have been allocated to these Centers (e.g., 38 to the Region 6 ISC in San Francisco), which are responsible to the Regional Directors. The ISCs have principal responsibility for developing, verifying, and implementing new modules for the DHCP, as well as providing support services for the Medical Centers. For whatever reason, the latter function seems to receive a rather low priority judging from the uniformly negative comments I have received from many Medical Centers. In any case, this is the black hole that has swallowed up the DHCP FTEE.

6. Q. I understand that the new quality assurance programs will rely heavily on the DHCP system. How many extra FTEE have you received to staff this function?

A. We have received no FTEE for quality assurance activities, either related to DHCP or not. All our quality assurance personnel have come from FTEE assigned elsewhere in the Medical Center. I should add, in fact, that with a single exception all of our QA personnel have added QA to their existing duties, since we cannot afford to assign them to QA alone.

As with the DHCP personnel (answer #5 above), the only FTEE allocated by VACO for QA have gone to the Regional Directors' and Districts' staffs. To the best of my knowledge, no personnel have been assigned to individual Medical Centers for QA. Furthermore, each Medical Center has been required to assign staff for part-time availability to Region and District QA functions, including MediPro. As a result, quite the opposite of receiving staff for these functions, we have been required essentially to give up staff for the purpose.

7. Q. What is the percentage of Category C veterans applying for care at your facility and how would the effectiveness and efficiency of your facility be affected if funds for Category C veterans were eliminated from your budget?

A. 4.6-4.9% of the veterans applying for care at this Medical Center are identified as falling into Category C. If funds for patients in Category C were eliminated, this Medical Center would sustain significant impairment of its effectiveness and efficiency for several reasons. First, the loss of funds and FTEE, if proportionate to the number of Category C patients, would require a disproportionate loss of direct medical care personnel because of the manner in which the RAM is applied. The reason that this is the case is that the RAM has to do only with direct medical care costs, so that up-front deletion of a segment of our patient base must affect the number of personnel assigned to medical care. It would be especially devastating if reductions were based on applicants for care rather than on care delivered. That sort of scenario would require that an a priori decision would have to be made that Category C patients could not be seen, since we would then know that resources would not be available. This amounts to denial of consideration for care without regard to medical need, a position which is abhorrent to health care professionals.

This in turn would inevitably affect our ability to care for patients in Categories A and B. The distribution of professional staff is based both upon the number of necessary specialty and subspecialty areas and on the minimum required for a critical mass in each such area. For a tertiary Medical Center to provide broad referral capabilities, it is essential that each area be covered 24 hours a day, seven days a week. Thus, a single neurosurgeon does not equate to a Neurosurgery capability. Rather, there must be a minimum of two neurosurgeons, a neuroradiologist, radiology technicians for CT, MRI, and interventional procedures, vascular surgeons, neurologists, operating room teams, anesthesiologists, technicians for EEG and evoked responses, ICU staff, clinical nurse specialists, rehabilitation staff, and so on. Many of these personnel obviously subserve multiple functions as well as support for neurosurgery, but all are required. A similar case can be made for most specialty and subspecialty capabilities. If the patient base is eroded to any degree requiring a reduction in these staff, the viability of many programs will be compromised.

One of the reasons that San Francisco VAMC has been able to develop and maintain its exceptional reputation for high quality care is that we recognize and sustain the important interactive nature of such constellations of services. We must never be forced to compromise any portion of this team, or we risk downgrading the entire effort. Morale in this Medical Center is high because everyone easily recognizes the benefits of our team approach.

Two important spin-offs from our team effort are an exceptional record in both education and research. The highest quality of patient care requires not only superb clinicians, but clinicians who are at the forefront of advances in medical knowledge by virtue of their personal involvement in advancing that front. When this is further coupled with bright, enthusiastic, and inquiring students and housestaff, the effect is remarkable to behold. Any reduction in staff would compromise our ability to sustain our teaching and research activities at their current level. This in turn would challenge the partnership that we enjoy with our affiliated medical school by potentially reducing our ability to sustain independence and equality. This Medical Center has an extraordinary relationship with the medical school because of our locally and nationally recognized strengths; it must not be jeopardized.

One of the marks of this Medical Center's strength is the relative ease with which it has been able to accept the challenge of the AIDS epidemic and to achieve a leadership role in both patient care and research in this disease. Were it not for the existing high morale, dedication, and staffing, we could never have been able to adapt to the increased workload (without proper funding) imposed by AIDS. The VA must always try to be in a position to respond to such challenges.

8. Q. How would you implement the proposed reduction of Category C funds and how would it be possible to prevent adverse consequences to Category A and B veterans?

A. I do not know that it will be possible to implement in an acceptable manner the proposed reduction of funds for Category C patients without causing adverse effects on care of veterans in Categories A and B. Because of the interaction described above (answer #7), the only viable alternative may be to target those programs with the least interdisciplinary interdependence and those that represent the least direct danger of loss of life or limb. This might include, for example, the Alcohol Dependency Treatment Unit, a portion of Audiology and Speech Pathology, and the Substance Abuse Treatment Clinic. Although we consider these programs important, their reduction, consolidation at other hospitals, or termination would be less devastating to our overall mission and would permit maintenance of full service programs in acute Medicine, Surgery, and Psychiatry. This is the wrong message to send to our veteran clientele, but I see no viable alternatives at this time.

9. Q. Is there a penalty, in terms of the RAM model, for providing care to Category C veterans or those that the Administration refers to as "low priority" veterans?

A. Yes, the workload reduction (line 2 of FY 87 Target Allowance) is based on each facility's percentage of (a) non-service connected veterans not in receipt of pension and (b) beneficiaries of other federal agencies. A copy of the document that describes the calculation of the workload reduction (identified by Health Resource Management Staff as Attachment A3, Exhibit 1) is appended to this reply as Appendix 2.

The workload reductions are based on patients treated and outpatient visits and result in reductions of both dollars and FTEE.

10. Q. The Committee has heard that Gramm-Rudman-Hollings cuts are still routinely taken out of medical center target allowances. Is that true?

A. The Gramm-Rudman-Hollings cut was officially imposed only once, but the effect is recurring since the cut was never erased. This is further compounded by the annually recurring 1% reductions in the name of efficiency. All Medical Centers are subject to the 1% cuts, but those at special risk are those also being cut by the RAM. The annual 1% cuts are cumulative so that Medical Centers have now been reduced 3% in three years. There can be very little question about the non-feasibility of increasing productivity as a result of such reductions. There is only so much that can be done during a working day, and reduced funding must lead either to a reduced workload or to a reduced quality of care. Since health care professionals are not willing to reduce quality of care, the number of patients being treated must be reduced. This in turn begins a progressive downward spiral because of the RAM, with recovery being highly questionable.

11. Q. Please describe to the Committee the restrictions on FTEE for research in the VA and what effect those restrictions have on the ability of the VA to continue its significant contributions.

A. FTEE in research have been limited in the annual appropriation for research. Although actual dollars available have sometimes increased, thanks to the extraordinary perceptiveness and perseverance of the Congress, the Administration has limited the availability of research FTEE to use those funds appropriately. As a result, Merit Review funds are often approved without accompanying authority for personnel, requiring that each Medical Center reallocate FTEE within its research ceiling, thus being forced to play off new programs against existing ones. This is further complicated by the requirement that extramural funds accumulated in a Post Fund for research purposes can be used for personnel only by competition for the same pool of research FTEE. Since medical care personnel cannot be transferred for use by Research Service, there is simply no current mechanism for an increase in FTEE to meet the need.

It would be ideal if research FTEE were not counted against an arbitrary ceiling. As is the case at our affiliated medical school, we should be able to recruit the number of personnel justified by our funds and to keep such personnel so long as funds are available. Thus, with some exceptions, research personnel should have term appointments with full employment benefits, with the understanding that the term can be extended if funding is extended. Thus, they would be in the same position as employees at the medical school who are recruited to meet the needs of a specific grant; they have no tenure beyond the duration of those grant funds. An arrangement of this nature would provide for the most efficient and effective use of research funds, without the unhealthy competition for a fixed number of FTEE. "Whose research is more important than another's" is an academic question at best and really has no answer until the results of the studies can be compared. We should not be required to make such decisions _a priori_.

CHAPTER 3. BUDGET EXECUTION

SECTION A. GENERAL

3A.01 SCOPE OF CHAPTER

a. Outlines the policies and procedures which govern the execution of the budget program at DM&S installations.

b. In the broadest sense, budget execution includes (1) apportionment of funds, (2) allotment and allowance of funds, (3) control of obligations and costs, (4) control of employment and personal services within established Central Office ceilings and/or floors, (5) comparison of actual program performance against planned performance, and (6) budget reports.

c. Budget execution begins with distribution of target allowances to the facilities followed by the Director's preparation of the Annual Budget Plan for all medical programs based on the target allowance.

3A.02 AACS (AUTOMATED ALLOTMENT CONTROL SYSTEM)

The Resource Management Office allocates target allowances with the concurrence of the respective Regional Director to fund the activities of the VA medical centers and several additional medical facilities. The transmitted funds are for numerous appropriations and programs and are made available to Resource Management through a Transfer of Disbursing Authority from the Director, Budget and Finance. The DM&S Allotment Control System replaces the manual system of managing the outstanding status of proposed allowances ("Target Allowances,") actual allowances, FTEE and workloads. Transactions entered into the AACS are transmitted via tape at the end of each day into the CALM system and are subsequently reflected on the status of funds. These transactions can then be compared with the AACS ledger printed weekly.

3A.03 INITIAL ALLOWANCES

Initial allowances will be based on the quarterly distribution of target allowances approved on the facility's annual budget plans, updated to include all subsequent actions approved by Central Office through the date specified on the initial allowance document. Initial allowances will be released by Central Office by October 1, or as soon as possible after enactment of the agency's appropriation.

3A.04 SUPPLEMENTAL ALLOWANCES

Requests for supplemental allowances will be processed by Central Office subject to availability of funds within the Department's allocation from the Director, Budget and Finance. Requests for increases by offsetting advances from subsequent quarters will be approved only if assurance is given that a deficiency operation will not result.

3A.05 POSTGRADUATE AND INSERVICE TRAINING—PROGRAM 813

Requests for additional details, lecturers, and other educational activities will be directed to ACMD for Academic Affairs (144C). Supplemental allowances to cover approved requests will be issued by Central Office and facilities will be notified of disapproved requests.

3A.06 FUNDING TERMINAL LEAVE AND SEVERANCE PAY

Directors will initially absorb in full the costs of terminal leave and severance pay for separated employees. Cost absorbed from unobligated balances will not be included in subsequent quarterly adjustment requests. Requests for funding, submitted to Central Office via the Quarterly Report of Needs/Excesses, for Medical Care terminal leave and severance pay expenses other than employee training programs will be for that amount that cannot be absorbed within available facility funds. Medical and Prosthetic Research appropriation payments will be made from institutional support funds. In unusual circumstances requests for additional Medical and Prosthetics Research funds will be submitted to the ADCMD (10B).

3A.07 FUNDING SHARING AGREEMENTS

Directors will initially absorb the costs of providing reimbursable services under sharing agreements (38 U.S.C. 5011, 5053 and 5054). The requests for funding, submitted to Central Office via the Quarterly Report of Needs/Excesses, will be for reimbursements earned through the preparation date plus the estimated amount to be earned through the remainder of the quarter.

3A.08 FUNDING OTHER REIMBURSABLE SERVICES

Directors will initially absorb the costs of furnishing reimbursable services to other appropriations or funds, such as personal services to the General Post funds. The requests for funding, submitted to Central Office via the Quarterly Report of Needs/Excesses, will be reflected on the line titled ".01 Miscellaneous (not included above)—Specify". The source for reimbursement will be explained and the amount of funds requested will be used for reimbursements earned through the preparation data plus the estimated amount to be earned through the remainder of the quarter.

3A.09 FUNDING WAGE RATE INCREASES

Central Office will review the Salary Adjustment Report, (RCS 10-0014 formerly RCS 10-131) and either increases the concerned facility's target allowance or issue subsequent allowances (formerly VA Form 4564, Transfer of Disbursing Authority) for the amounts required in the current and remaining quarters of the fiscal year. See paragraph 3D.01 for instructions for preparation of Salary Adjustment Report.

3A.10 FUNDING MINIMUM RATES AND RATE RANGES FOR SELECTED OCCUPATIONAL POSITIONS IN SPECIFIC GEOGRAPHICAL AREAS

a. **General.** Rates and rate ranges are those authorized by the Office of Personnel Management under 5 U.S.C. 5303 and other health care personnel under MP-5, part II, chapter 3, sections C and D and the DM&S Supplement thereto.

✓ b. **Funding.** Facilities are expected to fund 100 percent of the total cost. Facilities that cannot absorb this should contact their respective Regional Director for assistance. Should specific funding become available, separate instructions will be issued.

3A.11 FUNDING TRAVEL

a. **Noncentrally Directed.** Provision has been made in the Medical Care target allowance for noncentrally directed transfers and temporary duty details. Directors are responsible for controlling expenditures to ensure the facility will operate for the entire fiscal year within the established travel allocation. Emergency requests shall be forwarded to the appropriate Regional Director.

b. **Centrally Directed.** Central Office will provide Medical Care funds for centrally directed episodes of travel for the estimated cost on the authorizing document. Funding requests for the following categories will be submitted to the appropriate Regional Director (10BA__/10A2B2) and include: (1) Name and title of traveler, (2) mail routing symbol of authorizing element, (3) purpose and (4) estimated cost of travel and transportation by subaccount and limitation.

(1) **Permanent Change of Duty Station (Centralized Positions).** Funds may be requested for cost of transfer of individuals into the following positions or to facilities where they will receive training for these positions: (a) Director, (b) Associate Director or Assistant Director, (c) positions contained in DM&S Supplement, MP-5, part I, chapter 250, appendix A. Funds will also be provided to cover applicable costs for employees in the CMD Fellowship Program. In addition to the positions listed above, the following VA Central Office funded training positions will be funded: (a) Associate or Assistant Director Trainee, (b) Accountant, (c) Building Management Officer, (d) Engineering Officer, (e) Fiscal Accounts Supervisor, (f) Laundry Plant Manager, (g) Medical Administrative Officer, (h) Personnel Management Specialist, (i) Supply Management Officer, (j) Voluntary Service Officer, and (k) Chief Nurse Trainees. Travel costs associated with first duty appointment after completion of training will be funded.

(2) **Temporary Duty.** Funds may be requested for costs of travel associated with such requirements as EEO Grievance Examinations, Merit Systems Protection Board proceedings (and related hearings), congressional hearings, National

Award Ceremonies, travel in connection with title 38 Disciplinary Boards, and travel required by the General Counsel.

c. **Research and Development/Postgraduate and Inservice Training Programs.** Instructions for the allotment of limitation (.007) employee travel funds will be published annually for these programs.

d. **Report of Needs/Excesses.** Report additional funds required or excess funds for withdrawal in accordance with paragraph 3D.02, Quarterly Report of Needs/Excesses—(RCS 10-0027 formerly RCS 10-193).

3A.12 FUNDING ACTIVATIONS

a. **Submission.** Facilities will submit equipment listings VA Form 10-1348, Nonrecurring Requirements Specifically Related to Approved Specialized Medical Service or Construction of Hospital and Domiciliary Facilities Projects associated with activating construction projects to the Director, Office of Procurement and Supply (92A) in accordance with VA Manual MP-2, subchapter E, subpart 108-75.

b. **Approval.** Upon receipt of the approved listing from Supply, Resource Management (10A2B1) will notify the medical center Director (00/04) of the tentative dollar allowance with the provision that funding is subject to availability of funds. Within 30 days the medical center will request a quarterly distribution of the allowance.

c. **Funding.** Based on the requested quarterly distribution from the medical center, Resource Management (10A2B1), will prepare funding action within current fiscal year budgeted amounts.

d. **Final Submissions.** Report additional funds required or excess funds for withdrawal in accordance with paragraph 3D.02, Quarterly Report of Needs/Excessed, (RCS 10-0027, formerly RCS 10-193).

3A.13 FUNDING SPECIAL PROGRAMS

The Director is responsible for providing budgetary support within the total target allowance for all special program activities which previously have been, or subsequently may be, approved as elements of medical care at a facility (i.e., blind rehabilitation, vocational counseling, medical media, audiology, etc.). Hospitals and domiciliaries which provide services such as laundry, bakery, etc., to other hospitals, domiciliaries or outpatient clinics will have included in the target allowance the funds required to provide these services. The value of such services will be excluded from the target allowance of the serviced hospital, domiciliary or outpatient clinics.

Attachment A3
Exhibit 1

Veterans Administration
Department of Medicine and Surgery
FY 1987 TARGET ALLOWANCE - MEDICAL CARE PROGRAMS

Narrative Description of Derivation of
Line 2 (Workload Reduction) and Line 4
(1% Productivity Reduction)

I. Introduction

For the FY87 Target Allowance, there are major budgetary constraints in the presidential budget that have impact on the Target Allowance as both FTEE and dollar adjustments to Line 1 - Recurring Base as of June 30, 1986. The major impacts are as follows:

A. Inpatient and Outpatient workload reductions

B. An OMB mandated 1% productivity recurring reduction.

A summary of these reductions is as follows:

	FTEE	$
Workload Reduction -62,000 Patients Treated -1,254,000 Outpatient Visits	(8294)	($387,890,000)
1% Productivity Recurring Reduction	(1939)	($57,200,000)

II. Methodology for Reduction of Funding and FTEE:

In order to fund the above reductions, adjustments have been made on Lines 2 and 4 of the FY 1987 Medical Programs Target Allowance in the following manner:

A. Line 2 Workload Reduction:

The VACO Medical Administration Service, as requested by the Director for Operations, provided data on reduced workload categories (see Attachment A2 for facility specific percentages). The reduced workload categories include: a) non-service-connected veterans not in receipt of pension and b) beneficiaries of other federal agencies. The source for this information was the RCS 10-004 (BPA1) for period ending 3/31/86. The Director for Operations and Regional Directors agreed that these percentages should be applied to each VAMC's patients treated and outpatient visits in order to derive the workload reductions.

Attachment A1 - Exhibit I - shows the Reduction of Patients Treated and Outpatient Visits with the associated adjusted dollar and FTEE reductions for each VAMC. The source for the FY 1985 patients treated is the VA Summary of Medical Programs for the period ending September, 1985. The FY 1985 outpatient visits were obtained from the data tapes at the Austin DPC for the AMIS segment number 223 (Outpatient Care Staff Visits to Clinics).

Methodology for Calculating Adjustments for Attachment A1 - Exhibit I:

Each VAMC's reduced workload percentage (Col. 3) was multiplied by its FY 85 Patients Treated (Col. 1) and FY85 Outpatient Visits (Col. 2) to arrive at a reduction of patients treated (Col. 4) and a reduction of outpatient visits (Col. 5). The dollar reduction for each VAMC was obtained by: a) multiplying the VAMC's reduction of patients treated (Col. 4) by $4,353 per patient treated; b) multiplying the VAMC's reduction of outpatient visits (Col. 5) by $87.90 per outpatient visit; c) summing the results of the dollar reduction for patients treated and outpatient visits (Col. 6). (The costs per patient treated and outpatient visits were obtained from the Office of Resource Management Budget Formulation (10R2) Staff. These costs were used in formulating the FY 1987 budget).

In arriving at the FTEE reduction, a percentage of personal services to total dollars, 65.8%, and an average cost per FTEE, $28,894.35 were obtained from the FY 1985 RCS 10-0141. Each VAMC's dollar reduction (Col. 6) was multiplied by 65.8% to obtain an amount of the personal services dollar reduction. This figure was then divided by the national average cost per FTEE to obtain a VAMC's FTEE reduction (Col. 7).

Each VAMC's reduction of patients' treated, outpatient visits, dollar, and FTEE, was adjusted to arrive at the targeted reductions in the Presidential Budget. The calculations for these adjustments were as follows for each VAMC:

1. Adjusted Patients Treated Reduction (Col. 8) =

$$\text{Each VAMC's Reduction of Patients Treated (Col. 4)} \times \frac{\text{National Targeted Reduction of Patients Treated (62,000)}}{\text{National Sum of Reduction of Patients Treated (544,448)}}$$

2. Adjusted Outpatient Visits Reducton (Col. 9) =

$$\text{Each VAMC's Outpatient Visits Reduction (Col. 5)} \times \frac{\text{National Targeted Reduction of Outpatient Visits (1,254,000)}}{\text{National Sum of Reduction of Outpatient Visits (7,158,980)}}$$

3. Adjusted Dollar Reduction (Col. 10) =

   a. Adjusted Patients Treated Reduction (Col. 8) X $4,353 per patient treated & Adjusted Outpatient Visits Reduction (Col. 9) X $87.90 per visit for each VAMC summed =

   b. National Sum of Adjusted Dollar Reduction = $380,112,600

   c. Therefore, adjusted dollar reduction (Col. 10) for the workload reduction as shown on line 2 of the target allowance equals:

$$\text{Each VAMC's Dollar Reduction (Result of 3a. above for each VAMC)} \times \frac{\text{National Targeted Dollar Reduction (\$387,890,000}}{\text{National Sum of Adjusted Dollar Reduction (\$380,112,600)}}$$

4. Adjusted FTEE Reduction (Col. 11) =

   a. National Targeted Dollar Reduction ($387,890,000) X National Percentage of Personal Services to Total $(65.8%)

   b. National Amount of Dollar Reduction which is Personal Services (result of 4a. above) ÷ National Targeted FTEE Reduction (8,294) =

   c. National Adjusted Average Cost ($30,773.04) Per FTEE

   d. Each VAMC's adjusted $ reduction (Col. 10) X .658 ÷ $30,773.04 = Adjusted FTEE Reduction

The adjusted dollar reduction (Col. 10) and adjusted FTEE reduction (Col. 11) which is displayed on Attachment A1 corresponds to the "Workload Reduction" of FTEE and Dollars on Line 2 of the FY 1987 target allowance.

B. Line 4 - 1% Productivity Reduction:

To derive each VAMC's 1% productivity reduction of FTEE and dollars, the indirect FTEE on the FY85 RCS 10-0141 (to include all FTEE not in the Resource Allocation Models excluding stipend FTEE) was summed for a system-wide total of 62,469.6 FTEE as shown on Attachment A-Exhibit 1. Each VAMC's "Indirect FTEE" was divided by the system-wide total to obtain a proportionate adjustment factor. This factor was then multiplied by 1,939 FTEE to derive the 1% productivity FTEE reduction for each VAMC. Each VAMC's total "Indirect FTEE" and "1% FTEE Reduction" are illustrated on Attachment A. The 1% FTEE reduction appears on Section 1, line 4 of the FY 1987 target allowance.

The dollar reduction for the 1% productivity was derived by first obtaining an average salary of $29,499.74 ($57,200,000÷1939). This system-wide average salary was then multiplied by each VAMC's 1% productivity FTEE reduction to obtain the individual VAMC 1% productivity dollar reduction. This figure is displayed on Attachment A-Exhibit 1, as "1% Dollar Reduction", and corresponds to the 1% productivity dollar reduction on Line 4 of the FY 1987 target allowance.